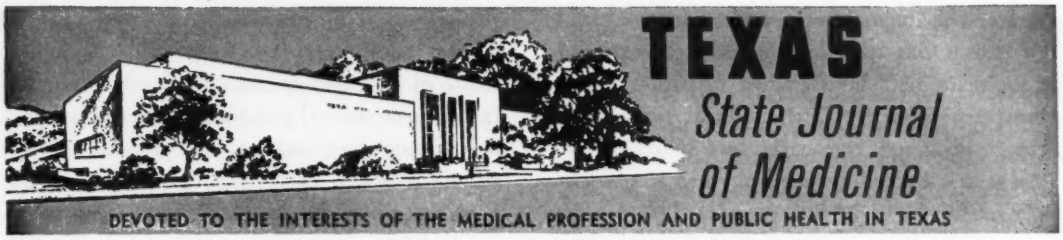

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Chronic Idiopathic Diarrheas

My bowels boiled and rested not; the days of affliction prevented me.

Job 30:27

The problem of chronic diarrhea is obviously an ancient one, but the utilization of the traditional and particularly some newer diagnostic techniques are making rapid inroads into the number of so-called chronic idiopathic diarrheas.

In the past, pancreatic steatorrheas were detected infrequently. Often the diarrhea appears only after the ingestion of excess fats, and even when pancreatic disease was suspected, the necessary studies to establish the diagnosis were time consuming and generally not available. Now, by the relatively simple procedure of feeding radioactive labeled fats and measuring blood levels and fecal excretion, a diagnosis can be made with considerable accuracy. Primary malabsorption also may be detected.

Lipase is essential for the absorption of the fatty acid triolein. Therefore when radioactive labeled triolein is fed and a low blood absorption curve with excess amounts of the radioactive material in the stool occurs, a deficiency of lipase is present, or a primary defect in the absorptive capacity of the intestine is suggested. By doing a second test, using radioactive labeled oleic acid, the differentiation can be made. Oleic acid is a simple fatty acid requiring no lipase for its absorption. A normal blood level curve and no excess of the radioactive material in the stool will occur even in the presence of pancreatic disease, while an absorptive defect in the bowel wall will result in a flat absorption curve and an excess of the radioactive oleic acid in the stool.

Primary malabsorption also can be recognized by the

use of d-xylose. When 25 Gm. of this sugar are fed to a normal subject after an overnight fast, 4 to 6 Gm. may be expected to be excreted in the urine in 5 hours, while in patients with absorptive defects of the small bowel the amount excreted is usually less than 3 Gm. This test is exceedingly simple and is particularly useful for screening purposes.

Once a defect of absorption is suggested, a tissue diagnosis may be obtained by the use of a small bowel biopsy. There are several instruments available for taking specimens for such biopsies—all are relatively simple to use and the risk involved is considerably less than with liver, kidney, or bone marrow biopsy.

Granted that diseases of the small bowel are not common, every patient with chronic diarrhea deserves a careful study of this organ. Even where radioactive materials or biopsies are not available, the radiological examination of the small intestine can generally be accomplished, and this examination is perhaps one of the most frequently overlooked. Regional enteritis, lymphoma, tumors, and other inflammatory small bowel disease can go unrecognized for months when a motor meal is neglected. The ingestion of ice water will speed up the bowel motility and allow for an accurate study of the small intestine without prolonging the procedure unduly.

The office procedure of proctoscopy, while certainly not new, is still not being done with the frequency it deserves, especially when it is recalled that 75 per cent of colonic disease can be detected with this instrument. Unless there is some obvious contraindication, every barium enema examination should be preceded by a proctoscopic examination. Chronic ulcerative colitis, neoplasm of the rectum and sigmoid, and amebic colitis may be seen before the barium enema reveals any abnormality.

Stool cultures rarely provide an answer in chronic diarrhea, since most specific diarrheas are self-limited. Cases of amebic colitis continue to go unrecognized, though in general, overdiagnosis seems more prevalent than underdiagnosis. New techniques are available for preserving fecal material and slides of fecal smears indefinitely. Such preparations should be made in all cases of chronic diarrhea, particularly where trained parasitologists are not available, since confirmation or negation of the diagnosis by an expert may be of critical importance when therapy is disappointing or unsuccessful.

Even after thorough study, frequently a group of patients with idiopathic chronic diarrhea will remain. The answer may lie in dietary indiscretions, an unsuspected medication, a metabolic disorder, or an emotional problem. A careful reexamination of the patient's story by the ancient technique of history taking may afford a solution.

—MARCEL PATTERSON, M.D., Galveston,
Past President, Texas Society of
Gastroenterologists and Proctologists.

Tuberculosis Plan Available

The occupational hazard of tuberculosis among employees of Texas general hospitals was first documented by a survey published in the June, 1954, issue of the *Texas State Journal of Medicine.*

It was shown that in spite of the extensive work-up examinations received by clinic patients in our best teaching hospitals, an occasional pulmonary lesion of active, contagious disease does escape detection and provide a source of contact infection for hospital personnel. To add to the tuberculosis hazard, an occasional unscreened employee has come on the job with active disease.

In an effort to meet the need for improvement in employee protection against tuberculosis, the Texas Tuberculosis Association in 1959 proposed preparation of a model program to be recommended to Texas hospitals.

The result is "A Tuberculosis Program for Employees of General Hospitals," copies of which may be obtained free from any local tuberculosis association office or from the Texas

Tuberculosis Association, 2406 Manor Road, Austin.

Essentially, the requirements of this model plan call for (1) pre-employment registration of each applicant's reaction to tuberculin; (2) follow-up periodic retesting of negative reactors, so that contact infections may be identified in early stages; (3) medical supervision of infected individuals (positive reactors) who may be accepted for employment; (4) retesting and evaluation of all personnel on separation from employment.

The thinking of many knowledgeable people went into evolution of this plan. A central committee of three outstanding chest specialists first prepared a draft of what they considered to be an adequate program; this was submitted for suggestions and criticism to an advisory committee made up of representatives appointed by their respective organizations, selected and invited to participate because of their interest in tuberculosis control. Eventually, a final draft was approved by both these groups.

The Texas Tuberculosis Association realizes that most, if not all, of our larger hospitals already employ programs of tuberculosis control, and doubtless some of these are entirely adequate. On the other hand, many hospitals know their programs to be weak, and it is this group who can profit most from the pattern laid out in the model plan now available for their consideration.

—J. EDWARD JOHNSON, M.D., Austin, President, Texas Tuberculosis Association.

A Friendly Decision

In action taken during the Fort Worth annual session, the Texas Medical Association House of Delegates voted not to make United States citizenship a requirement for membership in the Association.

By so voting, Texas doctors reaffirmed their friendship for foreign-born colleagues, some of whom received their medical education in America and others of whom, trained in Mexico, Canada, or abroad, are practicing admirably in Texas hospitals.

A thorough 8 months' study by the Board of Councilors preceding the April House of Delegates decision. Queried for opinions were Texas medical school officials, officials of Texas hospitals and special institutions, the State Board of Medical Examiners, and many others.

From the thinking of all these Texans stemmed the decision that a foreign-born doctor, accepted as medically-qualified by state licensure and having declared his intention to become an American citizen at the end of the prescribed 5 year waiting period, deserves to be welcomed into the Association.

For the protection of patients and the Texas medical profession alike, however, the House of Delegates recommended that the State Board of Medical Examiners be encouraged to prevent practice by nonlicensed doctors and that the Texas Legislature be urged to strengthen existing statutes so that annual permits or licenses will be refused to persons failing to carry out their filed "Declaration of Intent" to become citizens 6 years after licensure.

Most important, added the House, county medical societies must continue to accept the basic responsibility of judging the qualifications to practice of their own members, and it is at the county society level that individuals considered unsuitable for membership must be refused.

Members of the Texas Medical Association can pride themselves in having made a friendly and democratic decision tempered with what must be its constant concern for high medical standards.

President's Page

THE DOCTOR IS A CITIZEN

DR. OWEN

Frequently I read in the newspapers about some of our Texas doctors who are named to serve on the boards of various religious, cultural, philanthropic, or civic organizations. Always when I read of a doctor taking time out from his profession to serve in the role of citizen, I am proud—proud that he has not lost sight of his duty to his community.

The fine reputation which the "horse and buggy doctor," the family doctor of the past era, enjoyed was built in part on his willingness and ability to participate in many important phases of life in his community.

And, in these days of complex living, it seems to me that it is not enough for us to serve our neighbors just as physicians. It is necessary that we also shoulder our share of the responsibility in citizen's affairs along with many other busy professional men and women.

I have been privileged to attend three Medical Students' Days, the most recent being the one at Baylor University College of Medicine. In Houston, I had the opportunity to observe doctors who were not connected with the academic field of teaching, as such, devote time and energy to give senior students the benefit of their experience in such phases of medical practice as "Medical Etiquette," "Where Should I Practice?," "The Business Side of Medical Practice," and "Medical Law."

We all realize more and more every day the need for our being more than "just good doctors." It is our duty—and our rightful duty—to share in the building of our local communities, whether it be through the County Medical Society or through any other local, worthwhile group.

Let's all be encouraged to remember our status as citizens, despite the increasing demands of medicine, and share the responsibilities of this citizenship which many of our colleagues are accepting so admirably.

May Owen

Miss Harriet Cunningham: A Dedication

MISS HARRIET CUNNINGHAM

This issue of the *Texas State Journal of Medicine* is dedicated to the memory of Miss Harriet Cunningham, its longtime managing editor, who died in an Austin hospital May 8, 1960.

To the Texas Medical Association, as well as to the *Journal* it publishes, her loss is a tremendous one. Joining the staff in 1945 at the age of 25, she first worked as an editorial assistant with Association executives Dr. Holman Taylor and Dr. R. B. Anderson in the Fort Worth headquarters, and, upon their untimely deaths within months of each other, was forced to assume much of the responsibility for the magazine and for annual session arrangements.

She participated in the headquarters move to Austin, guided the *Journal* through changes of format and increase in size, saw it win several awards of excellence from the International Council of Industrial Editors. Despite the growing demands of *Journal* production, she continued to spearhead much of the year-round work on annual session arrangements.

As an expression of appreciation for Miss Cunningham's personal

and professional devotion to the Texas Medical Association, friends and associates are establishing the Harriet Cunningham Memorial Graduate Fellowship in Medical Writing at the University of Texas School of Journalism, her alma mater. Recipients of this fellowship through the years will be master's degree candidates of exceptional ability who will devote a large portion of their degree work to the medical writing field, thus preparing themselves for positions as medical reporters on newspapers, medical journal staff members, and medical association public relations specialists.

Miss Cunningham was born in Waco on May 3, 1920. She graduated from Waco High School as valedictorian of her class and attended Baylor University for 2 years. A gifted pianist, she turned away from music as a profession only because "I'm not good enough to be a concert pianist and nothing less is good enough." Instead, she received a bachelor of journalism degree with highest honors from the University of Texas, won a Sigma Delta Chi scholarship, and then took a master's degree in economics and English. While in college, she taught part-time as an assistant in English, journalism, and mathematics.

Active in civic and professional affairs, Miss Cunningham served on the board of directors of both the Fort Worth and the Austin YWCA. She was president of the Austin Professional Chapter of Theta Sigma Phi, national honorary journalism fraternity for women; an officer of the Society of Austin Industrial Editors; and a member of the Austin League of Women Voters, as well as of the Friends of the Austin Public Library. She was on the executive committee of the regional American Friends Service Committee for some time and belonged to the Business Women's Circle of the University Presbyterian Church in Austin.

Though a victim, for almost a decade, of a muscular disease and, in more recent years, of cancer, she was quietly famed in Austin for her constant good cheer and her devotion to her job. Travel, here and abroad, and attendance at almost all of Austin's major cultural events were her greatest pleasures.

As editor of the *Journal,* she carried on a voluminous correspondence with doctors across the state, many of them Texas Medical Association officers through the years who had become and remained her close friends.

At the April 9-12 annual session in Fort Worth, Miss Cunningham was presented appreciation bouquets of roses by the Council on Annual Session and by the Woman's Auxiliary of the Texas Medical Association. She was accorded a standing ovation by the House of Delegates.

She is survived by her mother, Mrs. Percy Moore Cunningham of Waco; her father, W. J. Cunningham of Comanche; a brother, W. Jack Cunningham, Ph.D., of New Haven, Conn.; and two nephews, Lawrence and John Cunningham of New Haven.

Memorial services were read in Austin, and burial was in Comanche.

Let's Return *POLITICS* to the People

JOHN McKEE, DALLAS, TEXAS

Too few citizens, including physicians, have shown enough interest in politics until recently. This has led to a situation in which special interest groups have too great a stronghold on government—threatening to unbalance the democratic processes of government in this country. Only by partisan political activity on the part of each voter can government be returned to the people—its rightful owners.

THE YEAR 1959 may go down in history as the year a slumbering giant awakened. From many sides evidence is gathering that the American people are rediscovering the personal importance to them of government and politics. Books based on political subjects almost are assured of quick success. Off-year elections, even of school boards, saw sprightly campaigns and attracted large turnouts. And members of Congress reported a flood of mail of proportions seldom ever witnessed before.

It seems clear that something has happened in this land to induce the ordinary citizen—doctors, lawyers, farmers, businessmen, housewives, and factory workers—to resume the personal exercise of citizenship rights they may have long neglected. They have made the decision to become effective citizens, and already they have demonstrated to a remarkable degree just how effective they can be.

The American people are showing interest in taking politics and government back from the special-interest pressure groups. Good! Let's return politics to the people. That's our best way to get better government.

In Congress, in state legislatures, and in government at all levels, activity has been very different from that which was foreseen after the elections of November, 1958. Many explanations have been offered for what has been called the "political miracle," and I believe that several are valid. But what is most apparent is that American men and women, individually, have given expression to their will in an unprecedented manner.

The fact that this action took place during what would have been normally a dull, non-election year is particularly significant. Traditionally, Americans become aroused during the full flurry of a political campaign, particularly in a presidential election. But, just as traditionally, in recent years they have gone back to sleep politically after elections. What can explain the difference now?

It has come about, I believe, because two influential institutions in American life have appealed to their members for new political and governmental awareness, activity, and effectiveness. The two institutions are, of course, organized labor and business.

The big political news of 1958 was the increased activity of organized labor in encouraging its members to political activity. In 1959 the big news was the emphasis given by business firms to encouraging employees to become active in the political party of their choice in their home communities, and to express their opinion to public officials on governmental issues affecting them as individuals.

Businessmen in Politics

This development has been identified loosely and incorrectly as a "business in politics" movement. It has been called more specifically "businessmen in politics." Actually, such a movement should not be confined to businessmen only. It should—and if it is to be successful, it must—include individual citizens of every kind and in every occupation.

Reports of this movement contain a great deal of talk about the "new" responsibilities of businessmen in governmental affairs and political action. But in truth the responsibility has existed all along, and for a long time businessmen have been doing something about their responsibility with varying degrees of intensity and effectiveness. What is new is the fairly recent discovery businessmen have made that it will be increasingly difficult to do business at all unless they also make government and politics their business.

During recent months we at Ford Motor Company have been besieged by delegations of businessmen coming to see us or writing to us for more information about the subject. And from an ever increasing number of platforms, business leaders are making this the topic of their public addresses.

Encouraged as we are to see this interest, I believe that it contains a danger. The danger is that all the talk will be construed as action on the part of businessmen. Speeches and articles are good and necessary, but they are only a prelude to work. Of themselves, they do not get the job done. People sometimes hear so much about a subject that they assume something is being done about it—if not by themselves, then by somebody else. This has happened a few times with over-publicized and under-implemented get-out-the-vote programs: everyone stays home on the assumption that everyone else is voting.

Several observers of the public scene today express the fear that a similar apathy will replace the activity that we have witnessed in the past few months. This might very well happen, I believe, unless people, all kinds of people, organize properly to see that this renewed interest is fostered and channeled into effective expression and that an equal interest is awakened in the other hundreds of thousands of Americans who still remain politically dormant.

I am convinced that a renewed interest in politics on the part of everyone, if properly encouraged and directed, will not be merely a fad or a momentary tempest that will blow itself out in a storm of words. It represents sober concern on the part of many responsible people, concern that the democratic processes of government in this country are in danger of getting seriously out of balance. I have no desire to be an alarmist, but I believe this concern is well-founded.

Danger of Special Interests

It is a truism that that government is best which most fully encompasses the interests of all the citizens. In America, we have also traditionally been able to include a wide range of interests under the banner of each political party. This has been a great source of our political strength, because we have managed to avoid the dangerous weakness of splinter parties dedicated to special interests.

In recent years, however, special interest groups increasingly have influenced the kind of legislation we have had on the federal, state, and local levels. In at least a few states, some party leaders are apprehensive that support from one such special interest group—organized labor—might turn into control by that group. But I need not single out the political activities of the big labor unions alone. Large trade associations, farm groups, veterans' organizations, and others are all bringing pressure to bear behind candidates, causes, and legislative acts.

I do not propose to argue that this activity is improper. But to the extent that it subordinates the general interest to a selfish interest, it is reprehensible. The real problem in thus narrowing the concern of government is that those Americans not actively represented by some special interest group are in danger of not being represented at all. Too frequently, what government does depends on which special interest group has the greatest power and

effectiveness rather than on what may be best for all the people.

Short of attempting to create a special pressure group for each segment of the population, the present condition can be corrected only by greatly increased political activity—and by that I mean partisan political activity—by every American who can vote. Only by partisan political activity on the part of all voters can we return to government of, by, and for all the people.

The chorus of businessmen calling for such activity has been swelling steadily in the past few months. Sometimes the impression is created that business is taking up the cudgels against labor in an area where the big unions have been conspicuously successful. I think that this is a very unfortunate impression. For one thing, business simply doesn't have the votes necessary to oppose politically a united labor front—if such a thing ever should develop. But for another and more important reason, there should be no fight. The present concern is not merely to see that business gets its fair share of representation; our over-riding aim should be to restore strength and balance to our democratic processes by building up the health and broadening the interests of both political parties. In short, our effort must be directed toward restoring politics to the people.

I believe that this concern is felt throughout our whole society and not just in the halls of business. It would be abhorrent to me to advance a business necessity as if it were a holy crusade, and that is not my purpose here. But the call to increased political activity has sparked so widespread a response that I am convinced business leaders have merely articulated a feeling of concern shared by many, many thoughtful people. The good sense of the American voter has in the past found the solution to many critical problems. Evidence indicates that it has been waiting only for leadership in the present situation.

The leadership that business can assume may take two general directions. One is what the corporation itself may do to make known its views to its stockholders, its employees, its elected representatives, and the public generally. I have on another occasion outlined a program for this kind of activity and have described what Ford Motor Company for several years has been doing along this line. To speak out on issues, to testify before Congressional committees—all these activities are vitally important to any business and they should be carried out vigorously and forthrightly.

Encouragement of Employees in Politics

However, today I should like to give principal attention to the other direction corporate political activity may take. I mean what the corporation can do to encourage its employees to work actively in the party of their choice. I am going to draw heavily on the experience of Ford Motor Company and the program we have set in motion to do even more.

It is a remarkable fact that the American people, for all their marvelous history of constitutional government, generally indicate so little political enthusiasm or understanding of politics. Our voting percentages are woefully puny, especially in non-presidential elections. Only occasionally does some candidate or some issue have sufficient appeal to call out crowds of voters. More often than not, we treat our heritage of freedom in pretty casual fashion.

John McKee, regional civic and governmental affairs manager of Ford Motor Company, Dallas, presented this talk before the Texas Medical Association Conference for County Medical Society Officials in Austin on January 16, 1960.

This is a bad situation, but perhaps it is the easiest thing in this area to correct. Voting percentages sometimes fluctuate widely and are not an absolutely reliable index of political activity. Voting is only part of the procedure. Just as dangerous to our system as not voting is a general indifference to the processes of party politics. Too few people appear to be aware of these processes.

How many know anything about the political leadership in their home districts and counties? How many consider party activity important enough to merit their financial support? You know the answers. And yet, many decisions regarding candidates and issues have been made before election day. They are decisions of vast importance to the operation of government in these United States. And these decisions are made by a relative handful of people—or by special interest groups—simply because most Americans at best treat political activity as a one-month pre-election flurry instead of a day-after-day responsibility.

It is not my purpose to assign blame for our general political apathy. The factors contributing to it are many and complex. Perhaps the political parties themselves have not seen the advantages of attracting and giving useful political work to those who are capable and willing but enjoy little influence. We as businessmen can do much individually and through our companies to reverse the dangerous trend away from political activity and to return politics to the people.

Accomplishing the Task

How can we accomplish our task? Briefly, we have three steps to take:

1. Make politics popular with people generally.
2. Inform people about politics and government.
3. Make political activity convenient for people.

What can we do to make politics popular? Probably our first job—if it has not yet been attended to—is to convince ourselves thoroughly that the task is necessary. It may help some, as it helped Theodore Roosevelt, to consider that only those who take part in practical politics belong to the governing class in a republic. This class, he said, is "composed of strong men who take the trouble to do the work of government; and if you are too timid, or too fastidious, or too careless to do your part in this work, then you forfeit your right to be considered one of the governing and you become one of the governed instead."

I realize that many businessmen find political and governmental affairs distasteful. They prefer the things they know: manufacturing, research, engineering, and selling. Although they may recognize the huge stakes involved for their own business, they nevertheless find it difficult, even in our political economy, to overcome their aversion to politics. In fact, the record of businessmen in politics has largely been one of aversion, of opposition, and of grudging yielding rather than a hopeful, constructive approach to national problems.

It is encouraging to see how many business spokesmen have advocated a better-balanced and more positive political approach. All I can say here is that it is necessary first for us to develop a genuine appreciation of the importance of government in our lives and a genuine interest in the processes that make government work. Only then will we be able to make politics popular with others.

This is not hard to do. Political and governmental activity can be tremendously exciting and stimulating. You have the companionship of like-minded people. You have the inspiration of a cause. You have the challenge of competition. You have opportunities for careful thought along with the hurly-burly of the campaign and convention. Above all, you have the assurance of vastly important, vastly worth-while activity. In all ages, some of the most influential men have achieved their accomplishments through politics.

Once you have convinced yourselves, what then? The American corporation can play a great part in renewing interest in others. Henry Ford II, in a recent address, said this:

> It seems to me that the best hope for stopping the present political drift toward a government controlled economy . . . lies in the political activation of a large, moderate, politically inactive middle-income group in our society. This group amounts, by one estimate, to 30 per cent of the electorate. It is the fastest growing group in the country, composed substantially of white collar and middle management employees. It could be playing a dominant role in politics. If it can be mobilized, it would provide a solid and wholesome buffer to extremes, of either the right or the left.

For years the corporation, with which this group is largely associated, has taken an unfavorable view of political activity. It has created the old aphorism that "business and politics don't mix." Understandably, the man in the corporation has neglected the greater part of his franchise—everything but the vote and sometimes even that.

Declaration of Policy

Now our business corporations must come out strongly and unmistakably in favor of political and governmental activity on the part of their employees. A vigorous, affirmative declaration of policy is essential to overcome the leftover attitudes of another era.

At Ford Motor Company, this declaration is a letter from Henry Ford II. Other companies have prepared specific policy statements or credos of political activity. The important thing is that there be a written declaration backed up by the genuine support of every administrator or supervisor in the corporation.

As a further evidence of its policy and because the importance of the matter requires it, a specific organization should be set up to administer civic and governmental affairs. In a company of any size, this cannot be a part-time activity. In medium sized companies, at least one full-time specialist should head the activity and, in larger companies, a staff may be required. I predict that within 10 years a new profession—the civic and governmental affairs specialist—will appear in American industry. I believe that he will have received special college training, have gained experience in political and governmental activity, and will be sought out by industry.

Ford Motor Company has adopted this kind of organization. Since December, 1950, we have had a Civic Affairs Office, with a small, full-time staff. The office has been expanded and the whole program broadened.

We are now putting into effect this new program at Ford Motor Company:

1. A Civic and Governmental Affairs Committee, composed of top management. This committee will review legislative and governmental matters that affect the company and will formulate our position in these matters. It also will re-

view all programs and proposed activities intended to implement the company's interest in such matters.

2. An expanded staff of specialists in the Civic and Governmental Affairs Office, including a research department.
3. A regional organization to consist of eight offices, manned by regional managers who have a particular knowledge of the region in which they serve. One of their functions will be to give direct assistance to local company management in civic and governmental matters.
4. An expanded program of public affairs information to our members of management through management bulletins, to our employees through their newspapers, to our dealers through our regular dealer publications, and an exchange of information with other business firms.

Our Civic and Governmental Affairs Office has been granted new organizational stature in the company to carry out this program.

Inform People About Politics

Step number two is to inform people about politics and government. Robert Louis Stevenson many years ago commented that "politics is perhaps the only profession for which no preparation is thought necessary." Perhaps because the country and its various governments have grown so big, nobody much believes that any more. Probably many people avoid politics simply because they recognize their own lack of preparation. Again, the corporation can do an important service in providing the necessary preparation.

Last fall we instituted training programs in practical politics. We began with a presentation of our civic and governmental affairs organization structure and approved plans at meetings with our management throughout the country. Then we are conducting in-plant training courses on practical politics. The in-plant courses are being conducted initially on an experimental basis. As the program develops, we will determine whether or not it justifies the preparation of booklets and training materials on practical politics for wider distribution.

We already have broadened bi-partisan discussion of public issues and governmental and political affairs both in employee publications and in management bulletins. In these discussions we make no mention of opposition to candidates or approval of them.

We are continuing to keep track of the voting records of members of Congress and will extend this service to include members of state legislatures as our regional organization gets into action. In this way our employees can learn readily how their legislative representatives have represented them.

Since training is pointless unless it is put into practice, we will intensify on a nationwide basis our recruiting of employee volunteers to work in the party of their choice in their home neighborhoods. Both political parties in the past have expressed their appreciation of our company's efforts to encourage employees to get into touch with their political leaders.

We will continue our meetings with government officials at company plants and offices throughout the country. These meetings give us all a chance to know one another better.

Restore Politics to People

The third major step in our effort to restore politics to its rightful owners is to make political and governmental activity convenient for people. I have already mentioned recruiting volunteers. The corporation can do more than this.

It is not the purpose of our political training programs to develop candidates for public office. However, as political activity increases under encouragement, it is very likely that many of our employees will seek office and will become elected officials. Hundreds of them have done so already. To indicate our willingness that they spend their spare time in such activity, we have set up a system to keep informed of who they are and what office they hold so that we may give them recognition in our company publications. Furthermore, letters of congratulation are sent by top management to Ford employees who have been elected to public office in the United States or who have achieved extracurricular success in the governmental and political field. We will extend nationwide our practice of having top management publicly present community service awards to those employees who achieve success in any type of civic service.

We recently announced a leave of absence procedure for employees who may be elected to full-time public office. So far as we know, it is the first of its kind in American industry. It provides that any employee who should be so honored and who therefore finds it necessary to take a leave of absence from the company is assured certain employment rights, benefits, retirement and pension program provisions, and the like—much as such assurances were given to employees in military service during wartime. We feel that this final step—making political activity convenient and trying to lessen somewhat the sacrifice it may involve—is important in our total effort.

In carrying out the program I have just described,

we at Ford Motor Company are very much aware that the mounting business activity in political and governmental affairs will be worthwhile and effective only to the extent that it merits public respect. This we intend to earn by the manner in which we conduct the program.

Certainly some serious and proper questions are going to be raised as businessmen become more active in this area. Let me cite four of the most basic questions and offer my answer to each of them. They deserve serious attention.

The first question is this: "Doesn't all this activity really amount to creating a big business party in this country?"

My answer is: No, there should be no intention of trying to create a big business party. For one thing, a corporation as such has no business dealing in party politics. For another, I am firmly convinced that it would be a grave mistake for business to align itself with either political party; in fact, it would be the surest way of creating a labor party. Both parties exert great political influence in this country, and both need more good men and women actively working.

I realize that a certain amount of skepticism about the sincerity of our bi-partisan approach must be expected. But I know too that we at Ford Motor Company intend to make it perfectly clear that we mean exactly what we say. We are convinced that the bi-partisan way is the best way, and that is the way we will take.

The second question is this: "Isn't this whole flurry of business activity aimed primarily at building an even bigger business lobby?"

Again the answer is no. Let me make it clear that, acting as a corporation, we intend to help articulate a business point of view on the public questions that concern the company. We feel that it is part of the democratic expression of all interested parties to make known the stand of the company on such matters, and we do not intend to be bashful. At the same time, we realize that we cannot formulate a point of view that fails to include our responsibility to the welfare of the whole nation. It may be difficult to resist narrow, self-interested objectives. We realize that. But we are convinced that we must apply ourselves imaginatively to the public problems of the day and attempt to offer constructive solutions based on the balanced interests of the whole community. It is only in this way that we will deserve public respect and achieve effectiveness.

The third question is this: "Isn't this just a drive to out-politic organized labor?"

I am quite sure I have already made it clear that the answer is no. It is undeniable that the political activity of the labor unions has served to stimulate the interest of businessmen.

However, we at Ford Motor Company—and I know this applies to a great body of business people throughout the country—see our program as something desirable even if there were no labor political movement in America. On some issues, our views will be in agreement. At times, no doubt, we will take positions on issues contrary to those adopted by organized labor. But certainly business and labor can disagree on public policies without the one being "anti-labor" and the other "anti-business."

The fourth question is this: "Isn't this an effort to regiment everybody into one camp or another, with everybody following an established company policy?"

This should never—under any circumstances—be the purpose of the program! We at Ford are convinced that such tampering with individual political liberty would destroy the very thing we are trying to help create.

We hope to achieve a government resting squarely on a two-party system that truly represents all the people in the United States. We have confidence in this system. We have prospered under it. We feel that our best hope for continued prosperity is under fully representative government. But this kind of government is not achieved through regimentation.

Individual Freedom

We are not adopting this program in order to tell employees what to think. They will be aware of what we say publicly about current issues, certainly, but there is no question whatsoever as to their right to disagree with company opinions or the individual opinions of any member of management. We are making it plain to everyone associated with our company that respect for individual freedom of decision is a cornerstone of our program. Otherwise, we are simply wasting our time.

Our efforts in one company mean little in view of the size and scope of governmental matters today unless they are joined to the efforts of thousands of others. We will do our best work with other companies and individuals and to share the experience we have gained through our own activities. For we are sincerely convinced that the best hope for our success as a corporation and for the welfare of the nation rests with the kind of government that *all* the people—interested, informed, and active in governmental and political matters—will provide.

♦ Mr. McKee, Regional Civic and Governmental Affairs Manager, Ford Motor Company, 718 Mercantile Continental Building, Dallas.

Dr. Walter C. Alvarez, professor emeritus of medicine, University of Minnesota Medical School, Chicago, presented this paper before the Section on General Practice at the Texas Medical Association's annual session, April 20, 1959, in San Antonio.

WALTER C. ALVAREZ, M.D.
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Many Nervous People Are More Psychotic Than Neurotic

Two types of nervous persons are described. One is the essentially sane and sensible person, but perhaps worn down with strain; the second is the one born to be poorly-adjusted and none-too-sane for all his days. For the first group, treatment will work well, but for the second, it often is unsuccessful.

AFTER 54 YEARS of talking to nervous people, I feel convinced that there is a tremendous need for distinguishing quickly between two main types. One is the person who is essentially sane and sensible, but is nervous, and perhaps tired out because of some heavy strain or prolonged overwork or great sorrow; and second is the person who evidently was born to be nervous, is poorly-adjusted, none-too-sane, and likely to suffer from nervousness and problems of behavior all his days.

So often, I have been disturbed because my able assistant failed to notice this tremendous difference between the two types of nervous patients he was seeing. Evidently, no one had ever trained him to note definite signs of a mild psychosis. Like me, until some years ago, he did not know that the early signs of a beginning insanity are abdominal pain with heart-consciousness, feelings of toxicity, weakness, great fatigue, and often diarrhea and indigestion.

What often caused me to marvel the more at my assistant's lack of interest in the fact that a patient was mildly psychotic was that my receptionist would see that a woman was nervous, but she would remark that, with it all, she was nice and sensible, pleasant, friendly, cooperative, and easy to handle.

Another time, the girl would whisper to me that a certain woman was a "screwball" or a "half-crazy" person who was making a nuisance of herself. Perhaps, she was coming up to the desk every 5 minutes to demand that she be shown right into my office, or smoking one cigarette after another, or running out to the toilet every little while, or perhaps annoying the other patients, and perhaps, when she could not have her way, getting nasty and abusive. Sometimes a laboratory woman also would comment on the fact that the latter type of patient made a scene when blood was being taken from her arm, or when an attempt was made to estimate her basal metabolic rate, or when the leads for the ECG were placed on her arms and legs.

All these signs of a lack of social sense, or lack of self-control, or lack of consideration for others, would reenforce my opinion—gained from a glance at the person, or her clothes, or from talking to her for a few minutes and noting the curious way in which she answered my questions and gave her history—that she was more than nervous; she was mildly psychotic.

This conclusion would be strengthened later when I came to sum things up and talk about treatment.

The sensible woman with a fatigue state would welcome my statement that her examinations had all shown her to be essentially normal, while the mildly psychotic woman, when told that she was physically well, might be incredulous or outraged. She might try to argue me out of my opinion and might show considerable ingenuity trying to prove that one of my statements was inconsistent with another. She might leave feeling disappointed and insulted, and later I might get a long, rambling, and nasty letter from her. Sometimes I could spot the mildly psychotic woman from the queer appearance of her mother, or one or two "goofy" sisters who came with her, or I would note the discourtesy with which my queer patient treated her relatives.

Often, on talking to the relatives while the odd patient was in another room, I would learn that she had had one or two episodes when she was "out of her mind." I might learn, also, that the family was afraid of her because of her bitter tongue, her violent temper, and her faculty for stirring up trouble.

Nice People Can Be Psychotic

The physician may be surprised in finding that an apparently "nice" patient is psychotic. Sometimes, even a pleasant and nice looking and apparently normal person soon will prove to be psychotic. For instance, one Saturday morning I was asked by a colleague to review the case of a beautiful and pleasant young woman who complained of some abdominal distress with occasional nausea and dizziness and diarrhea. Because a thorough examination had failed to show anything wrong, my colleague had been puzzled completely.

I was puzzled, too, until I happened to ask the woman if, over the dull week end in Rochester, she would go to the movies. She said, "No." She had formerly loved the movies, but since her baby was born, 2 months before, she could not stand the movies—she could not feel the slightest interest in the people up there on the screen. Next, I found that since her confinement she had lost all interest in her handsome husband, in her formerly adored mother, and even in her baby. I asked, "Where is your baby?" and she said, "I left him with my mother; I was afraid I would kill him." When I reported this to my colleague, he just could not believe it. He said, "She is too sweet and nice."

Another time I happened to see a rather beautiful and pleasant woman of 35. I saw her only because her home physician had asked that I see her about some abdominal discomforts she sometimes had. Because, when she arrived, I was out of town, a colleague saw her and had her operated on for a femoral hernia which he thought might account for her symptoms.

Day after day, on going to the hospital to call on her, I always found her out of her room. The nurse said, "You know, that is the most talkative and friendly and active patient I ever saw. She is all over the place, visiting all the other patients." With this, I got a hunch. When I finally caught up with her, I asked, "Are you always this full of energy?" "Oh, no," she said, "I am now on top of my wave, and talkative as can be; soon I'll be down at the bottom of the wave, and then I'll hibernate in my room for a few months." Perfectly obviously, she was a manic-depressive person. This was why she—a beautiful woman—had never married. When manic, she got beaus, but when depressed, she lost them.

Many of the patients going through the offices of physicians are decidedly psychotic, but no one notices this. One of my good friends, an able urologist, one day said, "Walter, because you can speak Spanish, I am sending you a wealthy South American man of 45 who has been seen and treated by several of the leading urologists of this country. For 3 weeks he has been pestering the life out of me, demanding that I keep looking into his bladder. I keep telling him I cannot see anything wrong, but back he comes. Now he is way-laying me in the hall. For goodness' sake, get him off my neck and preferably get him to go back home."

Noting that the patient looked sad and depressed, and that he talked slowly in a monotone, I asked him why he wanted so many genito-urinary examinations. He said, "I must suffer; it is the only way in which I can expiate the sexual crime which I think I may have committed against my wife. I cannot remember well; it is all hazy, but I fear that once I was untrue to her. The more the doctors hurt me and make me suffer, the easier my conscience is, and the less I have to think of suicide." Obviously, he was psychotic. But I went into the reception room, and, taking his wife and sisters into another room, I asked them what they thought of his sanity. They said, "For years, he has been crazy as a coot, just like his parents. He never has worked."

I can assure you that this problem is such a common one that if physicians will look carefully at all the people going through their office, they will soon find some cases of mild or even severe psychosis. To me, what is sad is that today, so commonly, when a psychotic woman is found to have a silent gallstone or a silent uterine myoma, she welcomes an operation for it, an operation which, of course, cannot do her any good. She is so anxious to get rid perhaps of a terribly distressing depression that she will accept any procedure that she thinks might bring quick recovery.

Today, the surest sign of wisdom in a physician or surgeon is his ability to say, in case after case, that

the gallstone found has nothing to do with producing the symptoms; they are all part of the person's psychosis.

Psychoses Are Common

Psychoses and equivalents of psychoses are common. Some readers may feel that what I am talking about must be rare, and, hence, not worth spending time on. But, no, there are some 750,000 insane patients being cared for in the hospitals of this land, and there must be as many more being cared for in homes. Every one of these persons has relatives, some of whom are somewhat psychotic. Let us remember that, during World War II, the draft turned down perhaps 1 man in 8 for mental reasons, and of the men the Army did accept, thousands now are in Veterans Administration mental hospitals.

How are the many mildly psychotic people in our offices now being treated? Not very well. At least 1 in 11 is being operated on—more or less unwisely. I have reviewed the subject at length, giving abstracts of the case reports of hundreds of cases, in my book, "Practical Leads to Puzzling Diagnoses: Neuroses that run through Families," (Lippincott, 1958).

I know that, in dividing my nervous patients into the two classes of neuroses and minor psychoses, I am not following the usual psychiatric classification, but I am not writing for psychiatrists. I am writing as a clinician for clinicians, and through the years, I have found my classification helpful. It serves my purposes and needs. When a patient comes into my office, I must first decide, if I can, whether he has only a functional trouble that no amount of testing will reveal, or whether he has an organic lesion which I can demonstrate.

If his trouble is functional, then I want to know, if only for purposes of prognosis, if he has a neurosis which may quickly be cleared up with reassurance, rest, a vacation, or some sedation, or if he was born to be a "crack-pot," or a "screwball," or a "queer bird." If he is going to be odd and eccentric, or shy, or unapproachable, or unemployable all his days; or if he will have depressions every so often; or if, whenever the going gets rough, he will take to the bottle; or if he can never love anyone or stay married to anyone; or if he often will behave as a spoiled child; or if he does not care to try to adjust to a civilized life; or if he will never learn to pay his bills and shoulder some responsibilities or hold his temper; and especially if he likes himself the way he is and sees no need for reforming, what can I or anyone else hope to do to make him over? Yes, I know, he may reform for a while, but he will never be safe, and he may never be happy or comfortable. Even an able psychiatrist, after years of effort, may be unable to change him much.

Person's Work Record

Incidentally, when a physician is taking a history, especially from an odd-looking man, he must ask about the fellow's work record. It can be tremendously revealing. Every so often I am astonished to hear a man of 50 admit that he either never had a job or he never could hold a job. He lived off his mother. Surely, such a bit of information should be in a man's medical history. It will probably be the most important statement in his whole record, but one seldom finds a young medical graduate who will ask every neurotic-looking man, "How many jobs have you had in the last 20 years?"

Naturally, the world is full of persons suffering from organic changes in their body, plus a mild psychosis, and they are the ones that will call for all the experience, knowledge, wisdom and good sense that a physician has. Then, the big questions will be, "How many of the symptoms are due to the organic disease, and how many are due to the psychosis?" "Will the patient be any better for an operation designed to remove the organic disease?" As we all know, today, the public's faith in surgery is so great that any psychotic woman who finds she has a little goiter, or a diaphragmatic hernia, or a uterine myoma, wants it fixed right off—even if her surgeon is reluctant to operate on her.

Through the years, as I have kept making notes on my nervous patients, I have found that the nice sensible one with a simple neurosis nearly always has a good nervous heredity. In 9 out of 10 cases he has had good, sensible, hard-working, successful, and respected parents, grandparents, uncles, aunts, sibs, cousins, and perhaps children. On the other hand, in perhaps 9 out of 10 cases, the "screwball" has one or more mentally disturbed, alcoholic, or violent-tempered relatives. These are unquestionable facts of observation. How a man is going to interpret them will depend on his bias and previous indoctrination or what degree of openmindedness he has.

An interesting point I learned while studying hundreds of families with a poor nervous inheritance is that, through the three or four generations about which I could get information, I would find that the apparently hereditary nervous or mental disease did not always breed true. For instance, a man with a psychosis might have an alcoholic brother, a mentally retarded son, an epileptic grandson, and a few nephews or cousins or sibs who were constitutionally inadequate, or unemployable, or had what looked like minor equivalents of psychosis, such as stuttering, enuresis, or hysteria. The epileptics whom I see

usually have relatives whose main trouble is great irritability and violence, perhaps with some alcoholism and psychosis, and, occasionally, epilepsy.

People often escape the serious psychic injury one would expect them to have gotten from a terrible environment. Years ago, the old giants of psychiatry used to face the probability that some of the men or women who came away mentally injured from a bad home—in which there was alcoholism, poverty, brutality, insecurity, and social shame—inherited some bad genes from the psychotic or alcoholic or epileptic father or mother who made the home the hell that it was. These old time psychiatrists used to face, also, the great implications of the fact that, usually, out of such a home came several good and able and successful persons who apparently did not get any of the bad genes. The one or two children who went to pieces nervously could well have been "chips off the old block."

Recently, I was much interested, while chatting in the office with a fine, able business man, to learn that he and his four sibs had come out of a terrible home. His father had been a brutal alcoholic who regularly beat up his wife and children, and only occasionally paid the rent or the grocery bill. My friend told me that out of the five children, three came out of that hell apparently unharmed by their miserable childhood—which strongly suggests that environment is not so all-important. My friend told me that his two brothers who grew up as alcoholics seemed, from their youth, to have inherited their father's great thirst for alcohol.

Psychosis Hard to Cure

It is often futile to spend time trying to cure the person with an inherited life-long psychosis. As I previously inferred, one big reason why, through the years, I have tried to differentiate the two main types of nervous persons is that, having only so many hours a day in which to see patients, I hate to waste my time. In most cases, I would be wasting my time if I tried to make over a psychopathic person who had apparently been born into a life-long tendency to psychosis. Often, I will soon see that a man has no persistent ability to mend his ways, and so to direct his steps and his energies that he can be well and happy and successful. Much of the time he may behave like a silly child with an adult body. Seldom can one teach him to live sensibly and hygienically. Sometimes he cannot leave alcohol alone or he keeps taking each day a handful of tranquilizers and barbiturates. Perhaps he tells me that, in him, there are two warring personalities, and the bad one can usually block the plans of the good one.

The worst patients are the mildly psychotic ones who have a low I.Q. Those I will not spend much time on, because I have found from years of sad experience that I can seldom help them. Neither will I spend time on a woman who thinks she knows it all, and who, when in my office, insists on doing all the talking.

In trying to explain this attitude of mine to graduate students, I sometimes tell Darwin's story about the man he knew who used to train monkeys for a vaudeville act on the stage. The man liked to take home from a pet shop 12 monkeys, and next day to bring back 11 that he said he could never train. When Darwin asked him how he could pick out the trainable one so quickly, he said that was easy. All he had to do was to keep the monkey that paid attention to him. Similarly, if in my office a mentally disturbed patient of low intelligence pays no attention to me, I dismiss him.

Summary

Every internist should try quickly to pick out all his patients who have no demonstrable disease. He should next try quickly to differentiate two main types of nervous persons: (1) those who are essentially sane and sensible, but perhaps worn down with strain, and (2) those who were born to be poorly-adjusted and none-too-sane for all their days. Some who are slowly going insane are complaining mainly of abdominal pain, fatigue, and feelings of toxicity.

Laymen know well the difference between the nice and sane nervous person and the "screwball" or "queer bird." Curiously, we physicians seldom make the differentiation. Usually, the patient's relatives know that he is "a bit off." If the physician will only spend time talking to the patient, he will be astonished to find that he or she is almost ready for a mental hospital or perhaps has been in one. Several cases of this type are described briefly.

This type of illness is common. In a man, it often can be recognized quickly by asking about his work record. Many mildly psychotic men have never worked steadily anywhere. Nine out of 10 of the sensible persons with a simple neurosis have a good nervous heredity, while 9 out of 10 of the mildly psychotic persons have a poor nervous heredity. A big reason for differentiating the nervous and the mildly psychotic persons is that, for the first group, the prognosis is good and treatment will work well; for the second group, treatment often is unsuccessful.

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Study of a new nonmercurial diuretic, chlorphthalidolone (Hygroton), indicates that it is more potent as a diuretic and as an antihypertensive agent than is chlorothiazide (Diuril). Chlorphthalidolone produces less potassium loss than chlorothiazide, has a longer duration of action, and appears to be a significant therapeutic advance.

Therapy of Edema and Hypertension

Comparative Clinical Effects of Chlorothiazide and Chlorphthalidolone

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With the Technical Assistance of Joan Bush
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SINCE THE ADVENT of chlorothiazide many new thiazide compounds have appeared on the market. The differences in these various compounds (when compared to chlorothiazide) have been restricted mainly to increased potency (on a milligram for milligram basis) and to a somewhat decreased potassium loss. Some observers have discounted the actual utilitarian value of these improvements.

However, at this time a new compound, chlorphthalidolone (Hygroton), has been introduced.[2] This new agent is a nonmercurial, long-acting, oral diuretic of the sulfonamide group—a derivative of the phthalimidine nucleus in contrast to the basic thiadiazine structure of chlorothiazide. It posseses the advantages of the newer benzothiadizine diuretics as well as certain other distinct improvements.

Chlorothiazide is available as Diuril, Merck Sharp & Dohme, Philadelphia.

Chlorphthalidolone will be available as Hygroton, Geigy Pharmaceuticals, Ardsley, N. Y.

Materials and Methods

Using bioassay techniques previously described[1] a comparison of the diuretic and antihypertensive properties of chlorothiazide and chlorphthalidolone was made. Pilot studies to determine the dose response of chlorphthalidolone were done on 10 patients with hypertensive cardiovascular disease. Comparative potency, duration of action, and electrolyte excretion effects were observed in two different groups of 10 patients with hypertensive cardiovascular disease. Changes in serum electrolytes were

observed in 5 patients in each group. Comparative effects in the control of hypertension were observed in 20 patients in each group.

Results

Dose Response.—Chlorphthalidolone was administered in incremental dosages beginning with 12.5 mg. and extending to 200 mg. as a single dose. The most significant response appeared to be at the 25 and 50 mg. doses (table 1). Although the 100 mg. dose demonstrated a slightly greater increase in sodium excretion, this dose was associated with some complaints of nausea and weakness. At the 200 mg. dose the patients complained further of nausea and weakness, and at this point there was a decline in sodium excretion.

TABLE 1.—*Urinary Sodium Responses to Single Doses of Chlorphthalidolone (average data from 10 patients).*

Dose (mg.)	Increase*
12.5	67
25	112
50	164
100	180

*Increase in urinary sodium excretion over control (mEq./24 hr.).

Duration of Response to a Single Dose.—Chlorothiazide, when given as a single dose of 2,000 mg. (under metabolically controlled conditions) had a duration of action between 12 and 18 hours. Chlorphthalidolone 50 mg., however, not only produced an increased sodium response (over that of chlorothiazide) but also had a duration of action of approximately 60 hours (fig. 1).

Twenty-Four Hour Urinary Electrolyte Excretion Patterns.—Twenty-four hour urinary electrolyte excretion patterns of chlorothiazide (200 mg. single dose) and chlorphthalidolone (50 mg. single dose) comparing sodium and potassium excretion pH changes and water excretion demonstrated that chlorothiazide produces less of an increase in sodium and water excretion and a greater increase in pH and potassium excretion (fig. 2). Of particular interest is the fact that during the 24 hours following the administration of chlorothiazide the urinary sodium/potassium ratio of increases was 2.3 while the ratio of the increases of sodium/potassium observed following the administration of chlorphthalidolone was 18.5.

Dr. R. V. Ford submits this paper from the Department of Medicine, Baylor University College of Medicine.

Serum Biochemical Changes After 7 Days' Consecutive Therapy.—Following 7 consecutive days of therapy with chlorothiazide 2,000 mg. and chlorphthalidolone 50 mg. it was noted that there was no significant difference over control in the serum biochemical architecture of the two groups of patients (fig. 3).

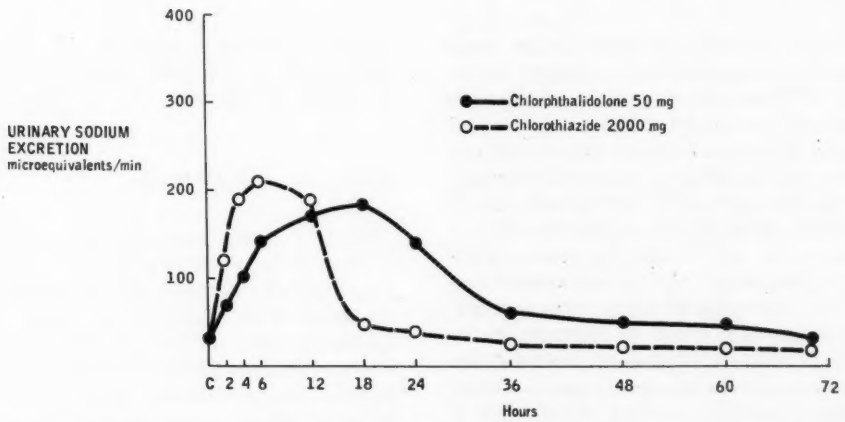


Fig. 1. The duration of action to a single dose of chlorphthalidolone 50 mg. is approximately 60 hours while the duration of action to chlorothiazide 2,000 mg. is 12 and 18 hours (average of 10 patients in each group).

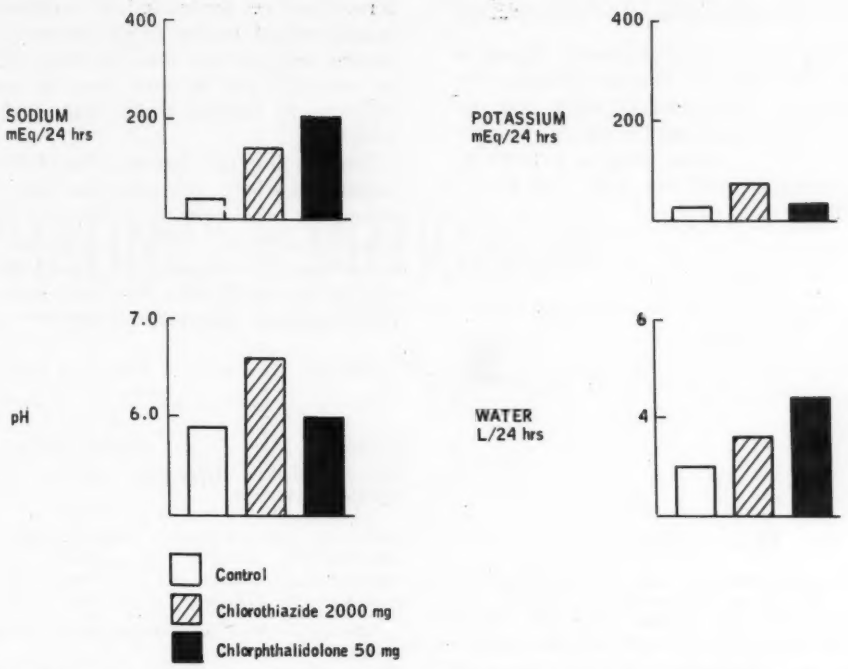


Fig. 2. Twenty-four hour urinary electrolyte excretion patterns reveal that chlorphthalidolone produces a greater sodium and water excretion with a smaller increase in pH and potassium excretion than does chlorothiazide (average of 10 patients in each group).

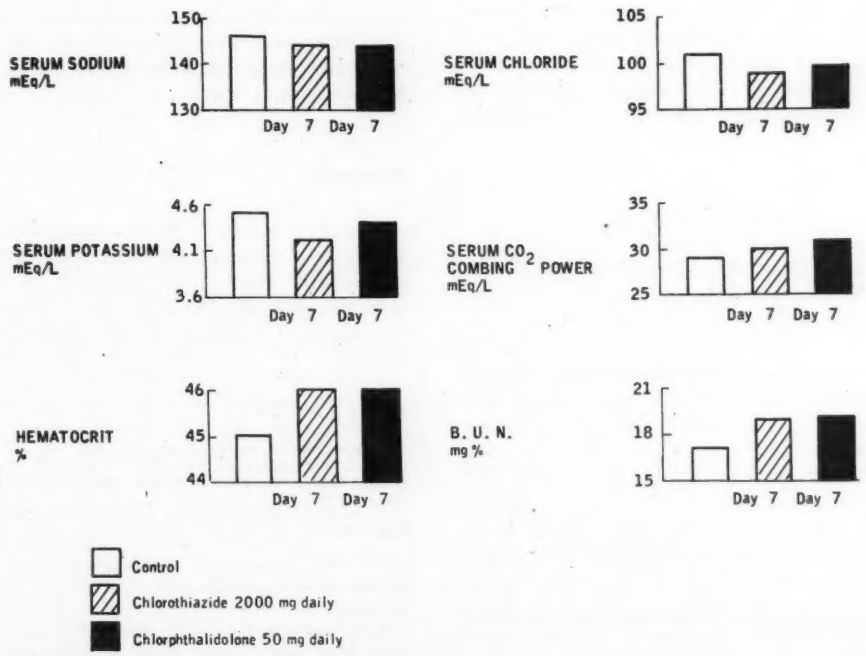


Fig. 3. No significant difference over control in the serum biochemical architecture was noted following 7 consecutive days of therapy with chlorothiazide and chlorphthalidolone (average of 5 patients in each group).

Effect of Diuretics as Antihypertensive Agents in Patients Who Have Had No Previous Therapy.—An apparently greater antihypertensive effect was observed with chlorphthalidolone 50 mg. in comparison to that noted in a similar group of patients receiving chlorothiazide 2,000 mg. daily (fig. 4).

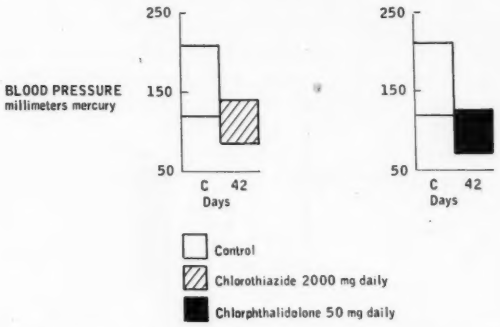
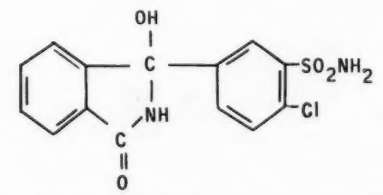


Fig. 4. When chlorothiazide and chlorphthalidolone were given to two groups of patients (20 patients in each) in effective dosages, it was noted that chlorphthalidolone produced a greater antihypertensive effect.

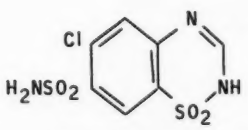
Discussion

Chlorphthalidolone, 3 hydroxy-3-(4 chloro-3- sulfamylphenyl) phthalimidine, is a new nonmercurial oral diuretic of the sulfonamide group and is a phthalimidine derivative rather than a benzothiadiazine derivative such as chlorothiazide (fig. 5). Although it was noted that 100 mg. of chlorphthalidolone produces further sodium excretion, extensive clinical research relative to the optimum dose of this diuretic indicates that doses in excess of 50 mg. are not necessary, and in most cases, optimum clinical effect can be achieved with a dose of 50 mg. every other day.

That the drug possesses the advantage of increased potency (not only on a milligram basis) is demonstrated by calculation of its potency estimation.* Chlorphthalidolone (orally) is 1.8 times as potent as meralluride intramuscularly. The potency estimations of various diuretics have been determined previously and are presented in table 2.



3-hydroxy-3-(4-chloro-3-sulfamylphenyl)phthalimidine
chlorphthalidolone



6-chloro-7-sulfamyl-1,2,4,-benzothiadiazine-1,1-dioxide
chlorothiazide

Fig. 5. Structural formulas of chlorphthalidolone and chlorothiazide.

TABLE 2.—*Comparison of Potency of Various Diuretic Agents.*

Diuretic	Route of Administration	Potency Estimation*
Chlorphthalidolone (Hygroton)	Oral	1.8
Hydrochlorothiazide (Hydrodiuril)	Oral	1.4
Meralluride (Mercuhydrin)	Intramuscular	1.0
Chlorothiazide (Diuril)	Oral	0.8
Chlormerodrin (Neohydrin)	Oral	0.5
Acetazoleamide (Diamox)	Oral	0.25

*Determined from previous analysis of variance of these drugs.

Another advantage of chlorphthalidolone resides in its more physiologic (and perhaps safer) urinary electrolyte excretion pattern. This drug is capable of producing a greater sodium excretion (with less of a potassium loss) than chlorothiazide. Two further advantages of chlorphthalidolone include its aforementioned longer duration of action and its greater antihypertensive effect.

Summary

Chlorphthalidolone (when compared to chlorothiazide) is a more potent diuretic as well as antihypertensive agent. This drug produces less potassium loss than chlorothiazide, has a longer duration of action, and appears to be a significant therapeutic advance.

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*This expression refers to the result of calculations derived from data obtained in an analysis of variance and compares each drug to a standard, such as meralluride, which is unity.[1]

CHRONIC URTICARIA

1. Approach to an Enigma

Chronic urticaria, an allergic reaction of the superficial cutaneous blood vessels apparently mediated by histamine, can be relieved most of the time. Certain food and drugs can affect the mast cells and incite hives. Other common causes include physical allergy, emotional tension, and infection and infestation.

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CHRONIC URTICARIA, a frequently encountered and vexing syndrome, often is dismissed by physicians as a "minor disease." To the patient, these maddeningly itchy swellings are well-nigh catastrophic. They interfere with his work and sleep, alter his (or, even worse, her) appearance, make him scratch in most unseemly locations, and drive him from one doctor to another—possibly to the psychiatrist eventually. This patient needs help; we can, with planned perseverance, afford him relief most of the time. The more we try, the more often we will succeed.

"Urticaria is a vascular reaction pattern of the skin characterized by the appearance of transient erythematous or whitish swellings in the skin."[12] The word is defined as "nettle-rash" (most appropriately) and derived from the Latin "urere," meaning "to burn." Various authorities have estimated that 15 to 25 per cent of all adults have had hives at some time; the majority of these have no other allergic manifestations.

Ordinary hives may be "minor" in the sense that they are not dangerous to life; complications can be decidedly dangerous. The major possibilities are listed in table 1. Laryngeal edema is a true emergency, requiring epinephrine promptly. Renal and collagen diseases are possible late complications of drug allergy, which may have been initially manifested as hives. Diagnosis and treatment of complications is beyond the scope of this article.

During the course of chronic urticaria, most patients intersperse episodes of angio-edema (giant hives or angioneurotic edema) with those of typical hives. There also may be attacks demonstrated by

TABLE 1.—*Complications of Chronic Urticaria.*

1. Laryngeal edema.
2. Gastrointestinal edema (Nausea and vomiting, pain, cramps, diarrhea).
3. Peripheral neuropathy (compression?).
4. Cerebral edema.
5. Renal disease.
6. Collagen diseases (?): lupus erythematosus, polyarteritis.
7. Myocardial affection (in serum sickness).
8. Exophthalmos?

the appearance of erythematous macules alone. Hives involve blood vessels of the upper corium, while angio-edema is a reaction of subcutaneous tissues. Thus, swellings are more diffuse in angio-edema, while hives itch more (more nerve endings in upper skin). The mechanism of these reactions is similar to that of Lewis' triple response to injury. Vasodilatation leads to local erythema, thence to local edema via increased capillary permeability. The spreading red flare is probably due to axon-reflex arteriolar vasodilatation. Histamine presumably mediates this response.

"The study of the mechanism of the production of urticaria has as its central figure the mast cell. It has recently been proved that the mast cell participates in all urticarial reactions. It is located about the finer cutaneous blood vessels and stores a reservoir of the powerful vasodilator substance, histamine. Any type of physical or chemical damage to this cell will result in a sudden outpouring of histamine, which causes a localized increase in the capillary permeability. Accordingly, serum proteins and fluid pass into the dermis in abnormally large quantities . . . . The depleted mast cell gradually reforms histamine, but it is significant to note that there is a period in which the mast cell histamine level is insufficient to produce further urtication . . . . During the process of whealing it is possible to demonstrate histologically that the mast cell granules are depleted or that they disappear. These granules contain the histamine and heparin . . . . The mast cell is very sensitive and an amazingly large number of chemicals cause the release of histamine from it."[12] Basophils are thought to be the circulating counterpart of the fixed mast cell; during bouts of hives, the total basophil count drops.

The most important clinical aspect of all this theory is the recognition of a group of substances, both proteins and simple chemicals, which affect mast cells *directly* to incite urtication via histamine release *without allergy* or any other mediating mechanism. Table 2 lists these substances; note how common some of them are (morphine, codeine, atropine, and others). This reaction should be classified as "idiosyncrasy," as in table 3, although "hypernomergy" would be more apropos. The urtication is an exaggeration of a normal response to the substance, rather than an allergic reaction.

TABLE 2.—*Histamine-Releasing Agents.*

Sensitizing compounds:	Antigens, haptens
Compounds damaging tissue:	Venoms, toxins, traumatic agents
Proteolytic enzymes:	Trypsin
Surface-active agents:	Tween 20, bile salts
Large molecules:	Egg white, dextran, P.V.P., horse serum, "Anaphylatoxin"
Histamine liberators:	Morphine, codeine, atropine, quinine, thiamine, pilocarpine, stilbamidine, Apresoline, Priscoline
Monobasic compounds:	Alkylamines

(After Paton, W. D. M. L.: Histamine Liberation and Lymphagogue, J. Physiol. 123:58P-59P 1954.) March

TABLE 3.—*Causes of Chronic Urticaria.*

1. Drug allergy and idiosyncrasy.
2. Food allergy and idiosyncrasy.
3. Infection and infestation.
4. Emotional factors.
5. Physical allergy.

FOOD AND DRUG SENSITIVITY

Foods which apparently can affect mast cells directly include strawberries, egg white, and shellfish.[17] Winkelmann[17] lists the following main food causes of hives (both allergy and hypernomergy): eggs, chocolate, nuts, fish, seafood, fresh berries, tomatoes, fresh pork, cheese, grapes, pineapples, and bananas. In my experience, the last four have been infrequent offenders. To the list, I would add all legumes, beer and other alcoholic beverages, cola drinks, mustard, melons, and citrus fruits. Proper investigation of food allergy requires strict elimination diets and trial feedings. I ordinarily eliminate all of the minor foods just mentioned as the first step, reverting to elimination of such major foods as milk, wheat, or eggs only if the patient fails to improve. No reliance should be placed upon skin tests without clinical confirmation of all results, positive and negative; in my office, no skin tests are performed for pure hives.

A major barrier to control of urticaria is the frequent multiple etiology, with several exciting and several predisposing factors combining variously to induce acute or continuing lesions. It is rare indeed to find a single food which alone accounts for the entire illness. It is equally rare to find emotions as the sole excitant. Drug allergy is probably the only excitant which usually acts alone. Examples of mul-

tiple causation abound, including milk sensitivity at high altitudes only,[2] the presence of chemicals in foodstuffs, and the frequent initiation of exacerbations by a minor illness, such as overindulgence or gastroenteritis. Leider[9] postulated that these latter conditions induce hives either because of the medications taken for the minor illness or through abnormal absorptive patterns of the inflamed gastrointestinal tract permitting introduction of polypeptides, which are primarily urticariogenic.

Drug sensitivity is now a common topic of medical discussion; only a few major points require emphasis here. First, drugs which cause reactions need not do so after each exposure. This may lull doctor and patient into a false sense of security; remember that the next reaction, especially to penicillin, could be fatal. After a drug sensitivity is proven, every patient should carry this information on a card in his wallet. Such individuals should never take drugs blindly; they have a right and obligation to question each doctor about medicines he is administering or prescribing.

Physicians can prevent most drug reactions by one simple procedure: *always ask the patient* what, if any, medications he cannot tolerate. Do not use the word, "drugs," since many people interpret this to mean only narcotics; some may even be offended by the question. After you have asked, *listen to the answer* and believe it, unless you have proof to the contrary. Many reactions (also, malpractice suits) could be averted by this simple procedure.

"Penicillin continues to be the most common cause of drug sensitivity today, surpassing even foreign serum in the production of fatal anaphylactic reactions. Between 5 and 10 per cent of the unselected population is now allergic to penicillin. Penicillin causes over 80 per cent of all drug eruptions . . . . Penicillin anaphylaxis is not avoided by the substitution of one type of penicillin for another, nor by the substitution of the oral for the injectable variety."[5] Anaphylactic reactions are not prevented by concurrent administration of antihistamines or prior coverage with steroids although these measures may minimize or prevent minor reactions. Two deaths have been reported from penicillin combined with adequate dosage of a good antihistamine.

The reference above to substitution of oral for parenteral penicillin applied only to anaphylactic reactions. Certainly, penicillin in any form should never be exhibited to any patient with a history even suggestive of severe systemic penicillin reactions. However, there is mounting evidence that a new synthetic oral penicillin (Syncillin) is the safest to use when penicillin administration is definitely indicated in patients with questionable previous minor reactions. The oral route permits greater control of dosage and quicker control of sensitivity reactions should they occur. How far we can go with Syncillin remains to be seen.

Do not rely upon penicillinase or steroids for sole treatment of penicillin reactions. Both take several hours to become effective; during the interim, other measures are essential. Penicillinase, despite the possibility of allergic reactions to it, can be invaluable for treatment of known penicillin reactions. It is also useful for etiologic diagnosis when penicillin has been given along with other drugs or may have been inadvertently administered or ingested via penicillin-containing foods, vaccines, syringes, and so forth. Penicillinase can be administered along with essential injections of polio, adenovirus, or other penicillin-containing vaccines. There have been very few reactions to Salk vaccine in penicillin-sensitive individuals although each should be approached with caution.

Cross-sensitization among drugs can account for reactions on initial exposure and for persistence of symptoms despite careful avoidance of the known cause. Common cross-sensitizers include the following: (1) neomycin and streptomycin; (2) Thorazine and Phenergan; (3) Vioform, Diodoquin, Quinolor, and Sterosan; (4) benzocaine, para-aminobenzoic acid, sulfonamides, and saccharine. There are and will be many more.

INFECTIONS AND INFESTATIONS

Infections and infestations frequently have been indicted as a cause of hives; their vogue waned with that of the "focus of infection" theory. They cannot be dismissed that lightly. Every patient deserves a complete history and physical examination, plus indicated laboratory procedures. Corrective measures can then be instituted to benefit the entire patient and, possibly, also eliminate the hives. I require a thorough dental examination and full mouth roentgenograms on each patient with chronic urticaria. Elimination of dental defects has been followed by cessation of hives in a group of patients.[15]

EMOTIONAL STRESS

Emotional stress, according to some writers,[11] can cause chronic urticaria; I do not believe this the usual cause. Emotions certainly can cause exacerbations in those who already have hives; it is less likely that the entire illness can be psychogenic. Each patient must be considered as the sum and result of interaction of body, mind, and soul. All chronic illnesses engender emotional effects which can, in turn, exacerbate the initial malady. So it is with hives.

PHYSICAL ALLERGY

"Physical allergy" includes urticarial reactions to trauma, cold, heat, and certain wavelengths of light. Dermographism is whealing following trauma and is readily reproducible by stroking the skin with a key or similar instrument. Lesions occur mainly under pressure areas, such as garters and belts. Primary dermographism is sometimes difficult to distinguish from hives. Not all urticaria patients are dermographic although it has been reported that dermographism is a frequent complication of penicillin reactions and can persist long after other evidence of the reaction has abated.[14] It is dermographism which makes skin tests so difficult to interpret at times.

There are four types of cutaneous cold sensitivity; (1) Cryoglobulinemia and (2) syphylitic paroxysmal cold hemoglobinuria are rare causes of cold urticaria, while (3) cold hemagglutination does not cause hives. (4) Essential cold urticaria is the most frequent clinical type; its lesions ordinarily are localized to exposed areas although generalized hives may appear in very sensitive individuals. The wheals appear after exposure ceases; primary vasoconstriction prevents immediate urtication.

As in other allergic manifestations, secondary factors may affect cold urticaria. "In isolated cases cold urticaria was found to be manifest only under specific conditions, such as after eating custard, pork-blood sausages or menthol lozenges. It has been found also in association with ascaris infestation, foci of infection, uterine fibroids, hypoacidity and hypothyroidism and cleared upon removal of these conditions."[6]

"When exercise, heat and emotions, or a combination among the three, increase the body temperature from 0.2° to 1° F., they cause the warmed blood to stimulate some heat-regulating center in the brain. This in turn sends nerve impulses along cholinergic nerves of the parasympathetic nervous system, which then releases its chemical mediator, acetylcholine. The skin of subjects who presumably are hypersensitive to this chemical then reacts with the production of cholinogenic urticaria . . . .The lesions themselves are so characteristic that the disease can be diagnosed clinically. They are small 1 to 2 mm. wheals, surrounded by a large axone reflex flare. When the lesions are confluent, huge patches of erythema are noted . . . . There is a second type of lesion that is characterized by minute discrete 1 to 3 mm. wheals."[7] Heat urticaria has been called "cholinogenic" or "cholinergic." Systemic symptoms may occur from it. This is the one kind of hives which is readily reproducible emotionally.

Dr. Albert H. Unger presented this paper at the El Paso meeting of the University of Texas Postgraduate School of Medicine, May 24, 1959.

Solar urticaria is rare although certain drugs, such as sulfanilamide, can induce photosensitivity in selected individuals. This can be reproduced artificially by injections of rose bengal; the resultant hives are histologically identical with all other hives. Roentgen radiation can produce urticarial lesions also.[16]

TREATMENT

Relief of chronic urticaria is ordinarily attainable when an etiologic diagnosis is possible. This problem must be tackled from all possible angles, beginning with a complete and searching history, a thorough physical examination, and such laboratory tests as are deemed necessary (table 4). Dental examination and roentgenograms should be required routinely. All medications should be eliminated other than those prescribed by the attending physician. Initially, I eliminate completely all those foods previously mentioned; stricter diets may be necessary later.

The Rowe elimination diets and similar strict regimens have a definite place in allergy, including urticaria on occasion. If the patient does not improve on moderate dietary restriction as mentioned earlier, I ordinarily switch to a routine which permits only five foods, plus products prepared from them. These are milk, wheat, eggs, beef, and chicken; the diet is rounded out by salt, sugar, and tea. This is a highly palatable diet for 3 days; after this, other foods are rapidly added if the patient is free from hives. If he is not clear, I switch to a wheat-egg-milk-beef free diet.

I also use food diaries, but recommend that these be expanded to include physical and emotional events which might influence the hives. This also provides a convenient wedge to discussion of emotional factors with the physician. The patient feels more confidence in a doctor who encourages frank talk without implications of emotional imbalance as the cause of all symptoms.

Medications for treatment of acute exacerbations are listed in table 5. Epinephrine still comes first; it is fastest and surest. Injections of 0.30 cc. of aqueous epinephrine 1:1,000 can be given deep subcutaneously combined with 0.05 cc. of Chlor-Trime-

TABLE 4.—*Diagnostic Approach.*

1. Complete and very detailed history.
2. Physical exam; lab work as needed.
3. Dental exam with full-mouth roentgenograms.
4. Elimination of all drugs.
5. Elimination diets.
6. Food and event diary.
7. Emotional attention as indicated.

TABLE 5.—*Drug Therapy for Acute Episodes.*

1. Epinephrine first.
2. Ephedrine, with sedative.
3. Antihistamines.
4. Temaril.
5. Nebulizer for laryngeal edema.
6. Tranquilizers?
7. Penicillinase?
8. Steroids: not usually necessary.

ton Injectable (100 mg. per cubic centimeter); no more than 0.50 cc. of epinephrine should be used in any one injection. Since epinephrine in oil is ordinarily suspended in peanut oil, a prime allergen, I prefer Sus-Phrine, a 1:200 suspension in sodium thioglycollate, for prolonged epinephrine action. Full adult dose is 0.30 cc. deep subcutaneously; I combine it with an antihistamine as described before.

First choice for oral treatment of acute episodes is ephedrine, which should always be combined with an antihistamine, tranquilizer, or sedative (various compounds designed for treatment of asthma may be used). Pure antihistamines, especially those with some sedative effect, are effective for less acute flareups. Tranquilizers (Phenergan might be first choice, inasmuch as it is both tranquilizer and antihistamine), Temaril, and intravenous calcium gluconate all are beneficial, as is penicillinase. A nebulizer (I prefer the Medihaler-Iso) affords peace of mind for patient and doctor since it quickly alleviates the dreaded laryngeal edema.

Steroids are rarely the drugs of choice although we are all forced to use them on occasion. Self-limited, potentially dangerous allergic illnesses, such as penicillin urticaria, provide the best indication for immediate exhibition of steroids. Full doses should be used at the onset and reduced as rapidly as possible. I prefer short courses, which can be repeated if necessary. Even though steroids are controlling the symptoms, the cause must still be found, if possible. If it is not, we have merely put off the problem for another day.

SUMMARY

Chronic urticaria, including angio-edema, is an allergic reaction of the superficial cutaneous blood vessels apparently mediated by histamine. The mast cells, which store histamine, participate in this reaction. Anything which damages mast cells can instigate the process. True allergic responses, especially to foods and drugs, as well as direct effect of certain common foods and drugs can affect the mast cells and incite hives. Other common causes include physical allergy, emotional tension, and infection and infestation.

Each of these factors must be investigated thoroughly and painstakingly in every patient. Only if the etiology can be determined is there a good chance of successful treatment. Palliative measures include epinephrine, antihistamines, such specific measures as antibiotics, dental care, and penicillinase. Steroid therapy is palliative and should be avoided except for drug reactions and severely ill patients.

With proper time and effort, most patients can be helped a great deal, provided that the physician keeps in mind the interplay of various factors which add up or contribute to the symptoms. A positive approach will produce positive results.

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Cyclandelate (Cyclospasmol), a new synthetic vascular spasmolytic and vasodilator, has recently been introduced for clinical use. In a study on 45 patients with peripheral vascular disorders, cyclandelate proved valuable. It was well tolerated and had no cardiac side effects. In the majority of patients improvement occurred within 5 weeks.

Effects of Cyclandelate (Cyclospasmol®) In Treatment of Circulatory Disturbances

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MEDIAL SCLEROSIS of blood vessels is considered to be both metabolic and a result of the aging process. The blood vessels become wider and longer; but there is no significant decrease in their capacity to supply blood except under extreme demand. Many believe that medial sclerosis leads to intimal sclerosis, that is, atherosclerosis. In this form of arteriosclerosis, there is a narrowing of the lumen of arteries and a decrease or subsequent failure of the blood supply. Narrowing of the lumen and diminution or failure of the blood supply results in a variety of clinical manifestations.

In arteriosclerotic changes in vessels of the extremities, the site of maximum involvement usually is the media. When degeneration is confined to the media, little change occurs in the amount of blood supplied. However, when thickening of the intima occurs, there is diminution or occlusion of the vessel lumen. Arteriosclerosis of this type may cause intermittent claudication, ulceration, gangrene, or other effects attributable to faulty metabolism or insufficient blood supply to tissues of the extremities.

Although the underlying disease is progressive and chronic in most instances, the ultimate aim of treatment is improved tissue metabolism. Established protective measures include protection from cold, avoidance of heat, vasoconstrictors, or any demand by tissues for increased nutrition or metabolism. Therapy also should include spasmolytics and vasodilators to relieve or prevent smooth muscle spasm and to dilate constricted arteries as well as vessels not necessarily constricted but which do not dilate under usual circumstances.

There are many oral and parenteral spasmolytic and vasodilating compounds, but none has proved entirely satisfactory. Some agents, such as xanthine derivatives, papaverine, nitrites, and organic nitrates, produce marked and rapid peripheral vasodilatation,

The cyclandelate used in this study was generously supplied through the courtesy of Medical Department, Ives-Cameron Company, New York.

but this is accompanied by a substantial decrease in blood pressure. In older age patients, such hypotension is certainly uncomfortable and is often dangerous. Other compounds increase the blood supply to some areas of the body but, in so doing, cause deprivation in another. Still other compounds increase cardiac output, and this is a distinct disadvantage in patients who have coronary insufficiency.

Usually when spasmolytics and vasodilators are pushed to the point of effectiveness, undesirable side effects occur. A rapid decrease in blood pressure may accompany nitrites and papaverine. Palpitation, nervousness, and decreased diastolic pressure are observed with nylidrin. Flushing of the skin, apprehension, palpitation, nausea and vomiting, severe postural hypotension, and syncope have been noted with Tolazoline. Weakness, dizziness, nausea, and other symptoms of hypotension are reported with azapetine. These side effects prompted me to evaluate cyclandelate, which other investigators have found to be well tolerated and produce a favorable response.

Cyclandelate

Cyclandelate, a new synthetic compound which is an excellent vascular spasmolytic and vasodilator, has recently been introduced for clinical use. Cyclandelate is the mandelic acid ester of 3,3,5-trimethylcyclohexanol. It is white or pale yellow in color, practically insoluble in water, and readily soluble in alcohol and in many organic solvents. The structural formula is as follows:

Its action on smooth muscle has been described as musculotropic because it acts directly on smooth muscle, in particular that in the wall of blood vessels and especially that in arterial walls.[3]

Pharmacologic and Experimental Investigations.—Extensive pharmacologic investigations of cyclandelate were first made by Funcke,[6] who found that the mandelic acid esters of trimethylcyclohexanol possess strong spasmolytic properties. According to Funcke, their effect on spasm of smooth musculature produced experimentally by barium chloride, acetylcholine, histamine, and other chemical substances is approximately three times greater than the spasmolytic effect of papaverine. In collaboration with Bijlsma[2] the marked vasodilation of these compounds was further demonstrated.

The effect of cyclandelate on blood pressure was studied by Bijlsma and others[2] and found to be either absent or slight. Toxicity of the mandelic acid esters of trimethylcyclohexanol is considerably less than papaverine. They do not offer side effects of decrease in blood pressure,[15] constipation, or drowsiness that have been reported with papaverine.

It was concluded by van den Akker, Bijlsma, van Dongen, and Ten Thijle[16] that improvement in vascular disease is due not only to the vasodilation and spasmolysis of cyclandelate, but also to a more rapid and extensive neoformation of blood vessels. Their conclusions were based on a comparison of tissues, microscopically, of treated and control animals in which blood vessels were ligated and tissue ischemia and necrosis were produced. These observations were confirmed by clinical studies in which the duration of ulcerations and other trophic changes was reduced by 30 to 40 per cent.

Ruberti and Magliulo[14] studied and reported duration, degree, and localization of cyclandelate on the circulation. Thermometric studies and plethysmograms, taken in two regions simultaneously, showed sustained improvement. This was reflected by an increase in the digital sphygmic wave, total digital volume, and skin temperature.

Clinical Investigations.—Based on Funcke's pharmacologic studies, Herschel[9] prescribed cyclandelate in spastic conditions of the blood vessels. The good results he obtained were confirmed by Kappert,[10] van Wijk,[17] and Gillhespy.[7, 8] One of the most important influences was the prolongation or complete disappearance of claudication time. (The time elapsing from the beginning of a "two-step" test, which involves mounting and descending steps in 5 seconds, and the appearance of the first symptoms such as feeling of heaviness and onset of pain.) Good results were found in patients who had arteriosclerosis obliterans, Raynaud's disease, and thromboangiitis obliterans. Poor results were obtained in acrocyanosis.[5] Cyclandelate was well tolerated, and noteworthy side effects were not observed even after prolonged administration.[1, 12] Doornink[4] and Reeder[13] used cyclandelate in the treatment of leg ulcers and concluded it had a highly favorable influence on healing. Leibetseder[11] observed rapid and excellent improvement, both subjective and objective, after 2 to 6 weeks of therapy in the majority of cases of peripheral and cerebral circulatory disturbances.

Present Clinical Investigation

The present study included 45 patients, 25 men and 20 women. Ages of patients ranged from 33 years to 85 years. The average age was 63 years. The diagnoses for patients appear in table 1.

Methods.—Each patient had a thorough physical examination, and a complete history was obtained. Blood counts, urinalyses, funduscopic examinations, and measurements of bromsulphalein excretion, thymol turbidity, and cephalin-cholesterol flocculation

TABLE 1.—*Diagnoses.*

Diagnosis	No. Patients
Arteriosclerosis obliterans	35
Raynaud's disease	4
Vascular headache	3
Labrynthitis	1
Leriche disease (acute bone atrophy at site of an injury or inflammation; Sudeck's atrophy)	2
	45

tests were done for each patient before cyclandelate therapy. These tests were repeated 1 week after starting therapy and bimonthly thereafter. In addition, liver function was measured in 13 patients, and the albumin-globulin ratio was measured in 4.

Treatment.—Of the 45 patients, 31 had previously received peripheral vasodilators (table 2). The usual dose of cyclandelate was 400 mg. daily, given as tablets of 100 mg. four times daily. In order to obtain maximum effectiveness, therapy was individualized and ranged up to 12 tablets daily. Initially, 37 patients received 4 tablets of cyclandelate daily, 7 patients received 8 tablets daily, and 1 patient received 12 tablets daily. In addition to cyclandelate, other previous medications, such as digitalis, glyceryl trinitrate, antibiotics, Rauwolfia derivatives, and quinine, were continued without change for 22 of the 45 patients. The total number of patient days of therapy was 3,453. The range was from 8 to 304 days. Many of these patients are continuing therapy on a maintenance basis.

The efficacy of cyclandelate was designated as *marked, moderate, slight,* or *none,* depending on the degree of improvement attained. Improvement was considered to be *marked* when the patient was completely free from symptoms, that is, free from pain, nocturnal cramping, or walking cramps. *Moderate* was used when the patient could double the distance walked without pain. Response was scored as *slight* when the patient observed improvement and could walk farther but still had pain. As a rule this group of patients requested that they remain on cyclandelate rather than return to previous therapy. *None* was used to designate no or poorer response change.

Comparison also was made of the effect of cyclandelate with previously used vasodilators. Response was designated as *marked improvement* when patient could walk much further, had less nocturnal cramping, less pain, and improved capillary filling. The term *moderate improvement* applied when there was moderate gain in walking, and slightly less nocturnal cramping and pain. *Same* was used when there was no change; and *less effective* when response was poorer than with previous medication.

Results and Discussion

Forty of the 45 patients receiving cyclandelate were judged improved. There was marked improvement in 18, moderate improvement in 15, and slight improvement in 7. In most instances, improvement occurred in less than 5 weeks after institution of therapy. In 5 patients there was not any improvement.

Of the 5 patients who failed to respond to therapy, 1 was uncooperative and had taken medication only sporadically. A second patient had coronary insufficiency and an old myocardial infarction. The third patient had generalized arteriosclerosis, particularly median artery sclerosis (Monckeberg's arteriosclerosis) although peripheral pulses and so forth were good. This patient has been a difficult therapeutic problem. He has had a chronic peptic ulcer with recurrent symptoms. Cyclandelate for 82 days has been well tolerated but no improvement has occurred. Two other patients who failed to respond to therapy had vascular headaches which were believed to be of psychogenic origin. When cyclandelate was used in conjunction with promazine for one of these patients,

TABLE 2.—*Efficacy of Cyclandelate Compared with Other Therapy.*

Previous Therapy	No. Patients	Response to Cyclandelate: Marked Improvement	Moderate Improvement	Same	Less Effective
Nylidrin HCl	10	6	3	1	—
Nicotinic acid	2	1	1	—	—
Azapetine	1	1	—	—	—
Azapetine and nicotinic acid	1	1	—	—	—
Tolazoline HCl	11	4	4	3	—
Tolazoline HCl and nylidrin HCl	2	1	1	—	—
Tolazoline HCl and nicotinic acid	2	—	2	—	—
Nylidrin HCl and nicotinic acid	1	—	1	—	—
Nylidrin HCl, nicotinic acid, papaverine, and dioxyline phosphate	1	1	—	—	—
Total	31	15	12	4	0

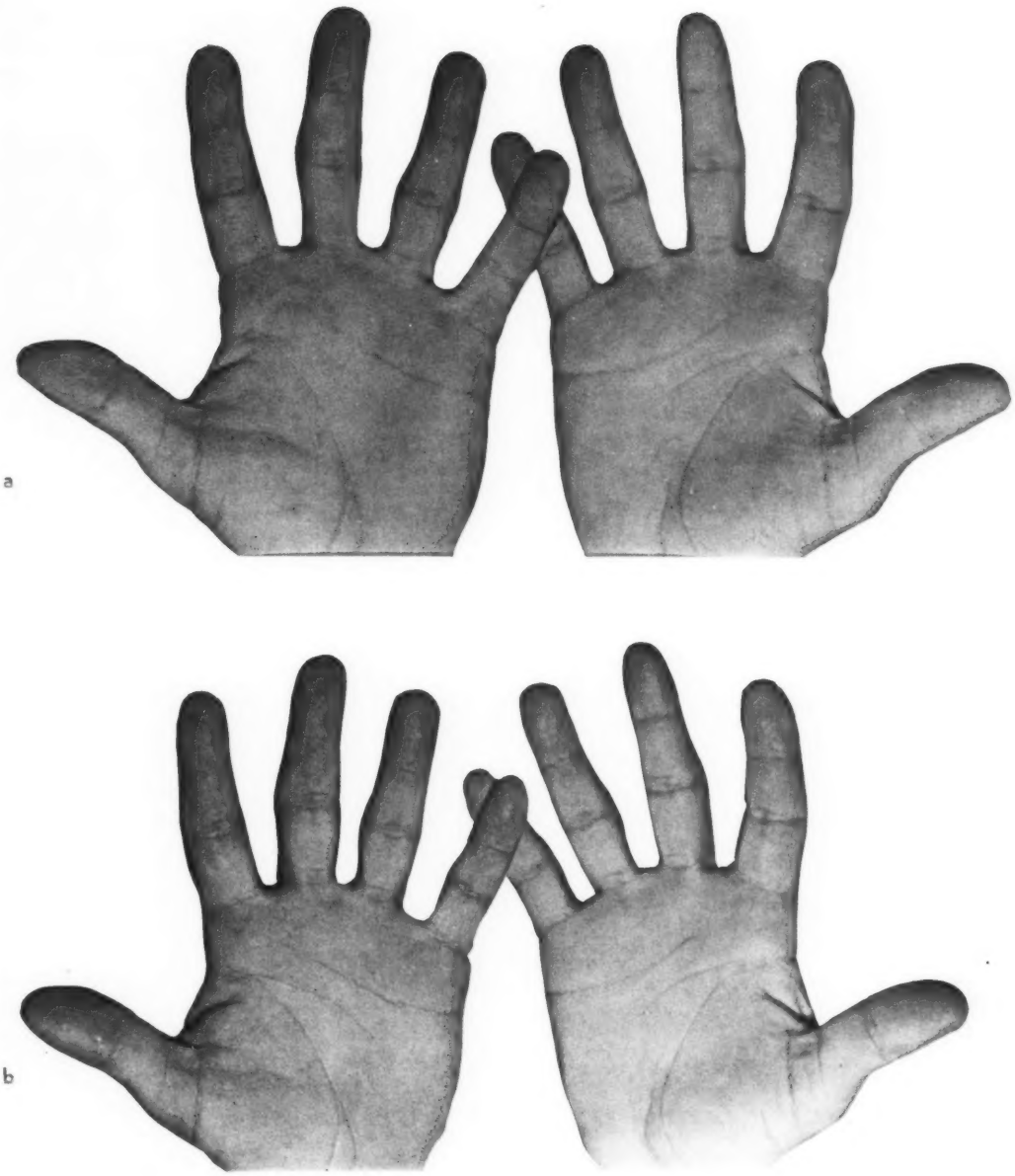

Fig. 1. Case 5. **a.** This view was taken before cyclandelate therapy. A cold immersion test was carried out in which the hands were submerged in water at a temperature of from 38 to 40 F. for 1 minute. There was considerable pain within 30 to 40 seconds after submersion.

b. This view was taken 21 days after institution of cyclandelate therapy. A cold immersion test was carried out. The tips of the fingers are no longer blanched. There is considerably more evidence of color in both hands. Symptomatically, the patient felt better.

relief was obtained whereas promazine alone was ineffective.

Two patients who initially received 400 mg. of cyclandelate daily were sufficiently improved to require maintenance medication only periodically. Four patients obtained greater improvement on a dose of 800 mg. daily.

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During the first week of therapy, transient, slight nausea was noted in 3 patients, but this could not be clearly ascribed to the medication. It was not necessary in any instance to reduce or stop therapy. These 3 patients have continued to take cyclandelate medication for periods of 304, 117, and 81 days without untoward effects.

Complete blood count, urinalysis, blood pressure determination, a general physical examination, and funduscopic examination were done before therapy, 1 week after therapy, and bimonthly. There were no significant changes and no evidence of depression of hematopoiesis. The albumin-globulin ratio was normal for the 4 patients in whom it was measured. Liver function studies including bromsulphalein excretion, thymol turbidity, and cephalin-cholesterol flocculation were done in 13 patients and were normal in all but 1 case. Jaundice developed as a result of tolbutamide therapy in this 1 patient. It cleared in 7 days after tolbutamide therapy was discontinued. Cyclandelate therapy was not stopped.

In comparison of cyclandelate with previously used peripheral vasodilators, it was found that cyclandelate produced *marked* or *moderate improvement* in 27 patients (table 2). Of the 31 patients who had received peripheral vasodilators previously, 15 obtained a *marked* response to the cyclandelate. In 12 the response was *moderate*. The response was the same in 4 patients.

Case Reports

The therapeutic value of cyclandelate in treatment of patients who have peripheral vascular disease is clearly demonstrated by the following cases.

CASE 1.—M. W., male, 72 years. *Diagnosis:* Coronary occlusion and arteriosclerosis obliterans. The patient was unable to walk because of severe pain in both legs. On the great and middle toes of the left foot there were several areas of early gangrene. *Consultation:* Two general surgeons and an orthopedic surgeon advised amputation. No pulse was palpable in the left ankle or foot. *Treatment:* The patient was hospitalized and given cyclandelate, 3 tablets four times daily (1,200 mg.). *Course:* Noteworthy improvement occurred. After 4 weeks, a feeble pulse was palpable in the left foot. The areas on the toes began to improve. This patient, who was previously unable to walk at all because of pain, was able to walk and did so without pain. On reevaluation by the orthopedic consultant, amputation was no longer advised.

CASE 2.—H. E. R., female, 66 years. *Diagnosis:* Severe arteriosclerosis obliterans. *Consultation:* Sympathectomy was advised because of severity of the disease, the lack of pulsation in the ankles, and the small areas on the tips of the toes that lacked circulation. *Previous therapy:* Nylidrin hydrochloride, Tolazoline, vitamin E, and low cholesterol diet had been ineffective. *Treatment:* Cyclandelate, 8 tablets daily (800 mg.), was prescribed for a period of 206 days. No additional medication was given. *Course:* Blanched areas on the toes cleared, and the right posterior tibial and left dorsalis pedis pulses became palpable. The capillary response to pressure improved. Surgical intervention was no longer considered necessary.

CASE 3.—L. T., female, 47 years. *Diagnosis:* Diabetic ulcer 10 cm. in diameter, ulcerative colitis, and severe obesity. *Previous therapy:* Tolazoline had been prescribed and was not effective. *Treatment:* Cyclandelate, 8 tablets daily (800 mg.), Cantil, tolbutamide, pantothenylol, Tryptar ointment, and prednisone (2.5 mg. four times daily) were prescribed for a period of 60 days. *Results:* Ulcer healed in 3 weeks. This patient had had previous ulceration which required grafting, lengthy hospitalization, and usually required from 6 to 8 weeks before the ulcer healed. With the use of cyclandelate, the ulcer healed in less than half this time.

CASE 4.—W. T. P., male, 76 years. *Diagnosis:* Intermittent and severe nocturnal claudication. Arteriosclerotic heart disease with failure. *Previous therapy:* Quinine, 5 grains, once daily and at bedtime. *Treatment:* Cyclandelate, 4 tablets daily (400 mg.), was prescribed for 67 days. Four days during this period medication was discontinued. *Results:* Marked improvement was obtained. The patient had a feeling of well being and could walk farther with less cramping. The heavy feeling in the legs also was ameliorated. There also appeared to be improvement in memory and the patient was more alert. During the 4 days in which the medication was discontinued cramping recurred. On resumption of therapy marked improvement was again noted.

CASE 5.—T. D., male, 40 years. *Symptoms:* This patient had spasm and pain in both hands. When it was moderately cold (40 F.), he wore fur lined gloves or kept his hands in his pockets. These symptoms had appeared approximately 8 years before and became progressively worse, so much so that he moved from Texas closer to the equator to be in a warmer climate where there would be less effect from the cold. Business required him to return to Texas. When this patient was first seen, there was blanching present in the little finger and the thumb of the left hand, and blanching in the thumb and middle finger of the right hand with evidence of gangrene in the tip of the middle finger. There was much pain on exposure to cold in both hands, but considerably more in the right hand. *Diagnosis:* Raynaud's disease. *Previous therapy:* During the 8 year period, nylidrin hydrochloride had been used but provided little relief from symptoms. *Treatment:* Cyclandelate, 8

tablets daily (800 mg.), was prescribed for a period of 21 days. Medication was continued but the dose was increased to 12 cyclandelate tablets daily (1,200 mg.) for 1 week, and then decreased to a maintenance dose of 4 tablets daily (400 mg.). *Results:* The patient has improved greatly. He no longer finds it necessary to keep his hands in his pockets or to wear gloves when there is any notable decrease in the temperature, such as to 40 F. Photographs taken before and after 21 days of cyclandelate therapy show that the blanched areas on the tips of the fingers and thumbs disappeared upon this treatment. There is no longer any gangrene on the middle finger of the right hand, and there is improved circulation in both hands. There is no pain; on a very cold day there is only slight blanching and slight discomfort.

Conclusions

Cyclandelate is valuable in treatment of peripheral vascular disease. It is an excellent spasmolytic in peripheral vascular disorders in which there is vasospasm and also in some obliterative vascular disease as evidenced by subjective and objective improvement observed in this clinical study. In the majority of patients, improvement occurred within 5 weeks after institution of therapy. Cyclandelate was often effective in producing a response in serious and chronic cases which failed to respond favorably to other forms of medication and treatment. It is well tolerated and effective in prolonged therapy using doses of from 400 to 1,200 mg. daily. No significant changes in blood or in liver function occurred. Transient, slight nausea in 3 patients was the only side effect to occur and was mild and of short duration. Its good tolerance and lack of cardiac side effects permit its use in the presence of coronary disease; it does not interfere with sympathetic nervous control; it can be used effectively in peripheral vascular disorders, whether superficial or deep; and can be given chronically with safety.

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Operation of a Summer Camp For Children with *Diabetes Mellitus*

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An evaluation of the experience gained from the operation of a 1 week pilot summer camp for children with diabetes mellitus is given. To reduce the risk of hypoglycemic reactions associated with the increased activity of camp, between meal and bedtime snacks as well as a reduction in insulin is advisable.

IT IS GENERALLY agreed among physicians working with juvenile diabetics that the summer camp represents a valuable educational experience. It provides an opportunity for the child to gain confidence in his own ability to care for his diabetes independent of parental supervision, while at the same time giving him a period of recreation similar to that available to his nondiabetic contemporaries.

The present report concerns the operation of a 1-week pilot summer camp for children with juvenile diabetes mellitus. For all but a few of the children and one of the authors, this was an entirely new experience. At the time plans for the camp were being formulated, a search of the literature revealed relatively little written on this subject.[2-4, 7-11] Therefore, it is hoped that a recounting of our experiences will be useful to others who contemplate similar projects.

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Camp sponsored by the Houston Area Diabetes Association, Inc., Houston.

Preparation for Camp

Several months in advance of the camp opening, announcements were mailed to the members of the local societies for pediatrics and internal medicine. This announcement contained a brief description of the camp and the fact that funds would be available to those diabetic children who otherwise would not be able to attend.

A packet containing further information concerning the camp, an application blank, and a medical information form was mailed to the parents who, at the direction of their physician, had contacted the local Diabetic Association office. Finally, a few weeks

prior to the camp date, an open meeting was attended by the parents, their physicians, and the camp medical and recreational staff.

Supplies

The supplies listed in table 1 were obtained for use at camp.

TABLE 1.—*Supplies Obtained for Diabetic Camp.*

1. Thirty U40/U80 insulin syringes.*†
2. Thirty no. 25—⅝ inch stainless steel needles.†
3. Thirty Clinitest and Acetest urine testing kits.‡
4. Two dozen U80 and two dozen U40 NPH insulin vials.§
5. One dozen U80 and one dozen U40 crystaline insulin vials.§
6. One portable pressure sterilizer.¶
7. One 20 cc. multiple dose vial of nembutal.
8. Six 1 cc. ampules of 1:1000 aqueous adrenalin.
9. Four 50 cc. ampules of 50 per cent glucose.
10. Four 250 cc. bottles of 5 per cent glucose/¼ NS.
11. Four no. 20 Gardner-Murphy infusion needles and four disposable plastic infusion sets.
12. Four 20 cc. and four 50 cc. syringes.
13. Eight no. 20 stainless steel needles.

*U40 or U80 only syringes should be used if the children are to give their own injections.
†Loaned by Hermann Hospital, Houston.
‡Supplied by the Ames Company, Elkhart, Ind.
§Supplied by the Eli Lilly Company, Indianapolis.
¶Loaned by the V. Mueller Surgical Supply House, Houston.

Admission Procedure

The parents had been instructed to arrive at the camp with their child between 2 and 4 p.m. Upon arrival, the children were given a snack and the parents interviewed briefly. The following points were ascertained during the interview: usual home insulin dose for the prior week; insulin dose given that morning; frequency, symptomatology, and usual time of occurrence of hypoglycemic reactions; presence of a convulsive disorder; enuresis; and medications. The children were weighed and their temperatures taken. The lower bunks were assigned to the younger children, those with a convulsive disorder, and those with a history of nocturnal hypoglycemic reactions. A councilor was assigned to sleep in each bunk-room.

Description of Campers

The camp was comprised of 24 children (table 2), ranging in age from 5 to 18 years, with an average age of 11.1 years and a median age of 11.3 years. There were 10 girls and 14 boys. Five of the children (3 girls and 2 boys) had had their diabetes for a period of less than 2 years. Four children (2 girls and 2 boys) were on anticonvulsant therapy. Three subjects (1 girl and 2 boys) were receiving an oral hypoglycemic agent (DBI) in addition to insulin. Two of the campers were brothers.

Fifteen of the children were in the fiftieth percentile or above for weight. Three of these were overweight. Only 1 child with diabetes for less than 2 years was below the fiftieth percentile for weight. Of the other 8 children below the fiftieth percentile for weight, 2 had parents who were also small. Height, unfortunately, was not obtained. The average weight age was 11.1 years.

One child (patient 24) received protamine zinc insulin, four children (patients 5, 13, 17, and 22) received Lente insulin, and the remainder received NPH insulin as their long-acting insulin while at home. One child (patient 5) received two injections of NPH insulin daily (7:30 a.m. and 5:30 p.m. respectively). She required 2.72 units of insulin per kilogram of body weight per day at home. Although a reduction to 1.72 units of insulin per kilogram per day was possible by the completion of the camp period, because of her relative resistance to insulin she is omitted from the calculations presented in tables 4 and 5 and from the mean of table 2.

Description of Staff

Medical.—There was at least one physician present at all times, and from early morning until bedtime two physicians were present. In addition, a dietitian, a nurse, and a senior medical student were present full-time.

Recreational.—There were three full-time councilors as well as two part-time councilors. The latter two presented courses in archery, tumbling, and the like; the former three supervised hikes, games, handicraft, swimming, nature study, and other recreational activities.

Operation of the Camp

General.—The 6 children with enuresis were awakened and encouraged to void approximately 1½ hours after going to bed.[6] This simple device sufficed in all but 1 of these children.

None of the 4 children who were receiving anticonvulsant medications had a seizure while at camp. All had had their diabetes for 5 or more years. Onset of the convulsive disorder followed the onset of diabetes mellitus in all but 1 child. This subject (patient 19) was also moderately mentally retarded. She did not fit well into camp activities.

Education.—Didactic instruction to such a group of diabetics, referred by many physicians with divergent concepts in regard to the management and ade-

TABLE 2.—*Summary of 24 Children Attending Diabetic Camp.*

Pt.	Duration of Diabetes (yr.)	Age (yr.)	Sex	Weight (Kg.)	Weight Age (yr.)	Diet	Episodes of Hypoglycemia	Insulin Type and Units/Day: Usual Home Dose	Insulin Type and Units/Day: Last Full Camp Day	Insulin Units/Kg./Day: Usual Home Dose	Insulin Units/Kg./Day: First Full Camp Day	Insulin Units/Kg./Day: Last Full Camp Day	% Change in Insulin Dose*
1	0.8	5.0	M	22.7	6.5	1		10 NPH 4 reg.	8 NPH	0.62	0.44	0.35	—43
2	0.9	12.2	F	35.5	11.0	1	1	18 NPH	20 NPH	0.51	0.45	0.56	+10
3	1.0	11.9	M	40.9	12.5	3		25 NPH	20 NPH 4 reg.	0.61	0.49	0.59	—3
4	1.3	9.8	F	33.6	10.5	2	1	22 NPH	18 NPH	0.65	0.48	0.54	—17
5	1.3	11.8	F	44.1	13.0	3	1	80 Lente 40 Lente	56 NPH 20 NPH	2.72	2.04	1.72	—37
6	2.0	8.3	F	31.8	10.0	1	5	40 NPH	26 NPH	1.26	1.01	0.82	—35
7	2.0	10.2	M	24.1	7.0	1	1	22 NPH 6 reg.	18 NPH 4 reg.	1.16	0.91	0.91	—21
8	2.0	10.8	F	29.8	9.5	2	1	8 NPH 2 reg.	10 NPH 4 reg.	0.34	0.20	0.47	+38
9	2.0	13.2	M	63.6	18.0	2	4	64 NPH 2 reg.	54 NPH	1.04	0.85	0.85	—18
10	2.9	7.9	F	25.0	7.5	1	2	42 NPH	34 NPH	1.68	1.36	1.36	—19
11	3.0	11.6	M	33.4	10.5	2		35 NPH	36 NPH	1.05	0.84	1.08	+3
12	3.5	12.8	F	40.0	12.0	1	1	46 NPH 9 reg.	34 NPH 6 reg.	1.38	1.13	1.00	—27
13	3.5	13.7	M	39.5	12.5	3		18 Lente	19 NPH 6 reg.	0.46	0.38	0.63	+37
14	4.6	12.2	M	43.2	13.0	3	3	44 NPH	32 NPH	1.02	0.79	0.74	—27
15	5.0	8.0	M	28.0	8.0	3	1	24 NPH	20 NPH	0.86	0.64	0.71	—17
16	5.0	9.6	M	39.3	12.5	2	2	29 NPH 6 reg.	22 NPH 4 reg.	0.89	0.74	0.66	—26
17	5.0	11.9	M	34.1	10.5	3	1	22 Lente	18 NPH 5 reg.	0.65	0.53	0.67	+3
18	5.5	11.0	M	43.4	13.0	3	2	26 NPH 12 reg.	22 NPH 10 reg.	0.88	0.65	0.74	—16
19	6.0	12.4	F	43.0	12.5	1		54 NPH 18 reg.	44 NPH 14 reg.	1.67	1.35	1.35	—19
20	6.0	13.3	M	54.1	15.0	3	1	48 NPH 20 reg.	32 NPH 10 reg.	1.26	0.98	0.78	—38
21	6.2	9.7	M	40.1	12.5	3	3	28 NPH	22 NPH 4 reg.	0.70	0.57	0.65	—7
22	7.0	9.5	M	25.9	7.5	2		15 Lente	16 NPH	0.58	0.46	0.62	+7
23	7.5	9.5	F	25.9	8.0	2		28 NPH	20 NPH 4 reg.	1.08	0.85	0.93	—14
24	16.4	18.9	F	43.4	12.5	1		30 PZI 10 reg.	28 NPH 8 reg.	0.92	0.74	0.83	—10
Mean	4.2	11.1		36.9	11.1					0.92†	0.73†	0.78†	—15†
Total							30						

An anticonvulsant agent was administered to patients 16, 17, 19, and 24.
An oral hypoglycemic agent was given to patients 3, 8, and 13.
One episode of symptomatic ketonuria was observed in patients 3, 13, 16, 21, and 23; 2 episodes were observed in patient 17; and 3 episodes in patients 8 and 18.
*Last full camp day dose in relation to usual home dose.
†Patient 5 not included in mean.

quate control of juvenile diabetes mellitus, requires considerable skill. Otherwise, the child may leave camp more uncertain of the role diabetes plays in his life than before he attended it. On the other hand, instruction by example, that is, influence of activity and constancy of diet upon insulin requirements, can be helpful.

No attempt at didactic instruction was made during this short 1-week pilot summer camp. However, any questions of either the child or his parents were answered frankly.

When the camp lasts for 3 or more weeks, it is possible to divide the time between assisting the child in the care of his diabetes and giving him a vacation from this responsibility.[9] More personnel than were present at this camp would be required to supervise self insulin injection and urine testing.

Urine Tests and Insulin Injections.—In view of

the short duration of the camp period and in order to provide as much of the children's time as possible for their camp activities, the insulin injections and urine testing was done by the medical staff. This was well accepted by all of the children except 1 (patient 24). She was considerably older than the others and special arrangements were made for her. The insulin injections were given at 7:30 a.m. and for 1 subject (patient 5) again at 5:30 p.m. Urine examinations for sugar and acetone were done prior to each meal and at bedtime.

Diet.—Information concerning diet was obtained from the parents as a part of the camp medical information form. It might be well to state here that, as a general rule, the mothers tended to underestimate the amount of food that their children consumed. The dietitian, herself a diabetic, converted the various forms of diet (weighed, measured, or exchange) reported to an exchange diet.[5]

Table 3 shows the three basic diets into which she was easily able to group the children and includes the increases in intake which were found to be necessary. Diet 1 furnished 58.9 calories per kilogram of body weight per day of which 19.9 per cent was derived from protein, 38.7 per cent from carbohydrate, and 41.4 per cent from fat; diet 2 furnished 59.7 calories per kilogram per day of which 19.9 per cent was derived from protein, 38.2 per cent from carbohydrate, and 41.9 per cent from fat; and diet 3 furnished 60.2 calories per kilogram per day of which 19.2 per cent was from protein, 44.2 per cent from carbohydrate, and 36.6 per cent from fat. In general, the younger and/or less active children were assigned diet 1, the older and/or more active children diet 3, and the remainder of the children diet 2.

Breakfast was served at 8 a.m.; a snack was given midway in the morning and afternoon activity periods, 10 and 3 respectively; lunch was served at 12 noon; dinner was at 6 p.m.; and a bedtime snack was given between 8:30 and 9 p.m.

Hypoglycemic Reactions.—It was decided that it would be well to adopt a regimen which would allow moderate glycosuria, rather than to incur the risk of hypoglycemic reactions which might mar the child's camping experience. Therefore, the urine sugar tests were frequently in the 2 to 3 plus range.

The children had been instructed to notify a councilor at the first indication that they were having a reaction. When the planned activity, hiking, fishing, horseback riding, and the like, required the children's absence from the main camp site, the councilors carried cube sugar. Bedcheck was made at midnight. Those children who had a negative urine sugar test at bedtime were awakened then and given 60 cc. of a 10 per cent glucose solution (Coke). There were no nocturnal episodes of hypoglycemia.

A total of 30 mild hypoglycemic episodes occurred during the camp period. More than half of these, 19, occurred on the first full camp day and were precipitated by the unforseen prolongation of the morning activity, a hike, into the lunch period. After the first day all episodes occurred in the half-hour period immediately preceding lunch or dinner. The symptoms consisted of one or more of the following: hunger, headache, perspiration, paleness, dizziness, and very minimal clouding of the sensorium.

No major hypoglycemic reactions occurred. All

TABLE 3.—*Diet for Diabetic Campers.*

Diet	Number Males	Number Females	Mean Age (yr.)	Mean Weight (Kg.)	Meal	Exchanges Milk	Meat	Bread	Fat	Fruit	Veg. A	Veg. B
1	2	6	11.0	33.2	Breakfast	1	1	1	1	1		
					Midmorning snack			1				
					Lunch	1	3	2	1	1	1	
					Midafternoon snack					1		
					Dinner	1	3	2	1	1	1	1
					Bedtime snack	1						
2	4	3	10.6	35.9	Breakfast	1	2	2*	2	1		
					Midmorning snack			1				
					Lunch	1	3	2	1	1	1	
					Midafternoon snack					1		
					Dinner	1	3	2	1	1	1	1
					Bedtime snack	1						
3	8	1	11.5	40.8	Breakfast	1	2	3†	2	1		
					Midmorning snack			1				
					Lunch	1	3	3	1	1	1	
					Midafternoon snack			1		1		
					Dinner	1	3	3	1	1	1	1
					Bedtime snack	1		1				

*Only 1 bread exchange for patients 4, 8, and 23.
†Only 2 bread exchanges for patients 15 and 17.

TABLE 4.—*Comparison of Campers by Duration of Diabetes.*

Classification	Sex	No. of Subjects	Average Weight (Kg.)	Average Insulin Units/Kg./Day Usual Home Dose	First Full Camp Day	Last Full Camp Day	% Change in Insulin Dose*
Diabetes less than 2 yr.	M	2	31.8	0.61	0.47	0.50	—18
	F	2	34.5	0.58	0.46	0.55	—5
Diabetes 2 yr. or more	M	12	39.0	0.90	0.71	0.76	—15
	F	7	34.1	1.20	0.96	0.97	—19

*Last full camp day close in relation to usual home dose.

TABLE 5.—*Comparison of Campers by Episodes of Ketosis.*

Classification	Sex	No. of Subjects	Average Weight (Kg.)	Average Insulin Units/Kg./Day Usual Home Dose	First Full Camp Day	Last Full Camp Day	% Change in Insulin Dose*
No Episodes of Ketosis							
Diabetes less than 2 yr.	M	1	22.7	0.62	0.44	0.35	—43
	F	2	34.5	0.58	0.46	0.55	—5
Diabetes 2 yr. or more	M	7	38.9	1.03	0.81	0.81	—21
	F	5	36.6	1.36	1.10	1.06	—22
One or More Episodes of Ketosis							
Diabetes less than 2 yr.	M	1	40.9	0.61	0.49	0.59	—3
	F	0	—	—	—	—	—
Diabetes 2 yr. or more	M	5	39.3	0.72	0.57	0.67	—7
	F	2	27.8	0.68	0.50	0.68	0

*Last full camp day dose in comparison with usual home dose.

were free of symptoms within a half-hour. None required epinephrine or parenteral glucose administration.

Insulin.—During the week of camp, NPH insulin was used exclusively as the long-acting insulin in all children. In anticipation of the reduced insulin needs with increased activity and in line with the idea of decreasing the risk of hypoglycemic reactions, the insulin dose on the first full camp day was arbitrarily reduced for all children by 20 per cent from the dose that they were accustomed to receiving at home. As can be seen in table 4, most children received essentially this same dose throughout the week of camp.

In keeping with the natural course of the juvenile diabetic to require much less insulin in the first 1 to 2 years of his diabetes, the children are grouped in tables 4 and 5 according to whether they have had their diabetes for less than 2 years or for 2 years or longer. As was to be expected, the children who had had their diabetes for less than 2 years were receiving, on a per weight basis, approximately half (mean of 0.60 units of insulin per kilogram of body weight per day) the insulin required by those who had had their diabetes for 2 years or longer (mean of 0.90 for males and 1.20 for females) at home.

Ketosis.—Thirteen episodes of symptomatic ketosis occurred in 8 children during this 1 week of camp. Symptomatic ketosis in these instances consisted of the occurrence of glycosuria and ketonuria without clouding of the sensorium and in association with one or more of the following: headache, abdominal pain, malaise, anorexia, nausea, and vomiting.

All were clear of ketosis in 2 to 6 hours following from one to three injections of supplementary crystaline insulin, with one exception. This child (patient 3) had an intercurrent infection (gastroenteritis of approximately 18 hours' duration, apparently viral in origin) and required four supplementary injections. The supplementary dose of crystaline insulin was calculated as that equal to 20 per cent of the 7:30 a.m. insulin dose for that day and was administered at 2 hour intervals as long as the ketosis persisted.[1]

Discharge Procedure

A copy of the child's daily log for the week of camp was given to the parents at the time they called for their child. The urine tests, insulin dosage, and episodes of hypoglycemia and ketosis were discussed with them. Any questions were answered and each was advised to return to the child's usual diet, activity, and type and dose of insulin.

Discussion

Those children who had had their diabetes for less than 2 years, as was expected, required less insulin on a per weight basis without sex difference than those who had had their diabetes for 2 years or longer. Of the latter, the females, probably because of their sedentary habits, tended to require

more insulin on a per weight basis than the males. This is particularly evident in their accustomed home insulin requirements and less evident in their camp dose.

The 13 episodes of ketosis were particularly distressing since only 1 episode was associated with an intercurrent infection. The single episode in 1 other subject (patient 16) is probably explainable on the basis of an emotional disturbance (complete inactivity brought on by homesickness). Table 5 is designed to elucidate what seems to be the most likely explanation for the remainder of the episodes of symptomatic ketosis.

It is obvious that in those subjects in whom no ketosis occurred it was possible, with the increased activity of camp, to sustain a 20 per cent reduction in the insulin dose. Conversely, in those subjects in whom ketosis occurred it was necessary, despite the activity of camp, to increase the insulin dose to one equal to or greater than the usual home dose.

These findings indicate that the majority of the ketotic episodes, particularly in the older males, was associated with the reduction of their insulin dose in anticipation of increased activity while at camp. However, since these subjects were already active at home, this further arbitrary reduction of 20 per cent in their insulin dosage, without regard to present home insulin dose on a per weight basis, resulted in ketosis.

The 3 children who were receiving an oral hypoglycemic agent (DBI) in addition to insulin is too small a group to be statistically significant. However, all 3 had one or more episodes of clinical ketosis in addition to the intermittent asymptomatic finding of ketone bodies in their urine. Two made up the only group of children requiring a significant increase in their insulin dosage (37 and 38 per cent respectively) from the usual home dose in association with the increased activity of camp. One (patient 3), who had had his diabetes for less than 2 years, required a dose of insulin comparable to the other children who had had their diabetes for less than 2 years but who were not receiving an oral hypoglycemic agent.

Summary

An attempt is made to evaluate the experience gained from the operation of a 1-week pilot summer camp for children with diabetes mellitus.

It would seem advisable not to include mentally retarded children in the camp.

Meal planning appears to be more convenient and still quite satisfactory when the exchange system[5] is used.

To reduce the risk of hypoglycemic reactions associated with the increased activity of camp, between meal and bedtime snacks as well as a reduction in insulin dosage is advisable. A reduction of approximately 20 per cent from the usual home requirements would seem to suffice in most.

However, it is suggested that a reduction below approximately 0.85 units of insulin per kilogram of body weight per day in males and below 1.05 units of insulin per kilogram of body weight per day in females be made with caution, lest it result in ketosis. In those subjects who have had their diabetes for less than 2 years, the lower "safe" limit of reduction would seem to be approximately 0.55 to 0.60 units of insulin per kilogram of body weight per day.

Acknowledgements

We would like to express our gratitude to Dr. C. W. Daeschner for his invaluable suggestions in operation of the camp and in the writing of this paper.

To Mrs. Donalda Jackson, the camp nurse, and to the other members of the camp staff we also take this opportunity to express our appreciation.

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Treating the Comatosed Patient

Value of Methylphenidate (Ritalin) Hydrochloride

Ritalin was used in 8 patients suffering from severe central depression, 5 from ethyl alcohol. Response appeared satisfactory with almost no side effects.

METHYLPHENIDATE (Ritalin) hydrochloride has been used in the treatment of patients suffering from overdosages of chlorpromazine, reserpine, barbiturates, alcohol-barbiturate combinations, promazine, and Lotusate and to shorten the recovery time after a general anesthetic.[2, 3, 7]

Probable Pharmacological Action

Hess[5] postulated that the subcortical system consists of two mutually antagonistic divisions, the trophotropic, and the ergotropic divisions. The trophotropic division integrates parasympathetic and somatomotor activities to produce behavioral patterns that conserve and restore energy. Trophotropic stimulation results in sedation, increased parasympathetic activity, and decreased muscle tone and activity. An example of a drug producing stimulation to this division is reserpine. The ergotropic division integrates sympathetic and somatomotor activities to produce patterns of behavior which prepare the body for positive action. The ergotropic division stimulation results in arousal, increased sympathetic activity, enhanced skeletal muscle tone and activity, and an activated psychic state. Chlorpromazine blocks this division, thus producing a similar action to reserpine. Mescaline, the amphetamines, and ephedrine stimulate the ergotropic division. Ritalin and Meratran also stimulate this division, but they have only a minor direct action on the peripheral autonomic system.[1]

Dr. Johnny Randolph Powell is a general practitioner at Pecos.

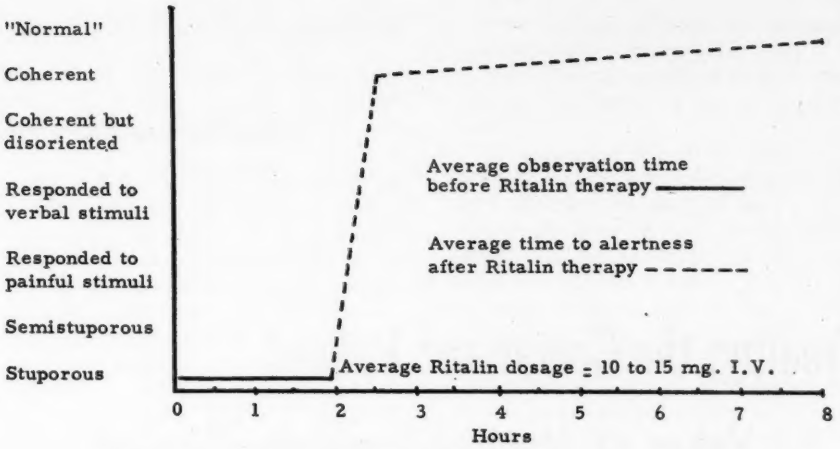

Fig. 1. Cases 1-5. Treatment of alcoholic (ethyl) induced depression.

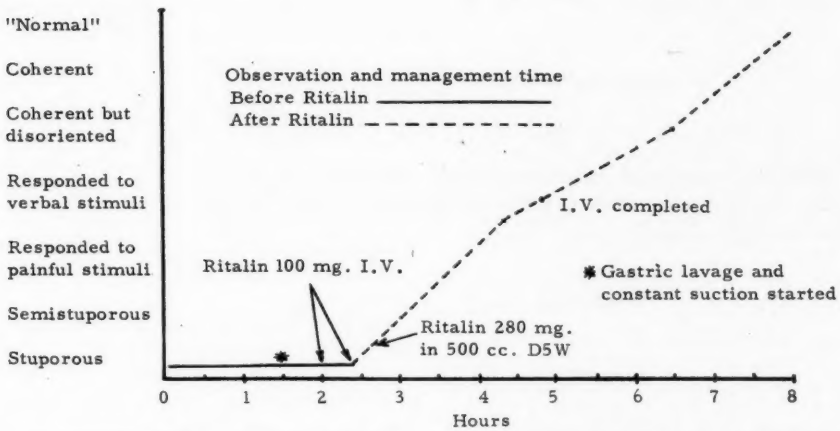

Fig. 2. Case 6. Treatment of alcohol (isopropyl) induced depression. The chart indicates the large amount of Ritalin required initially with this type of drug ingestion.

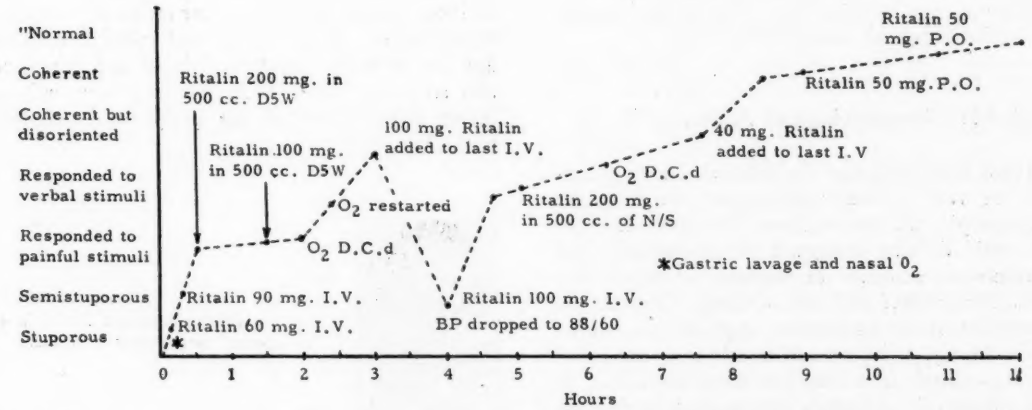
"Normal
Coherent
Coherent but disoriented
Responded to verbal stimuli
Responded to painful stimuli
Semistuporous
Stuporous
Ritalin 50 mg. P.O.
Ritalin 200 mg. in 500 cc. D5W
Ritalin 50 mg. P.O.
100 mg. Ritalin added to last I.V.
40 mg. Ritalin added to last I.V
Ritalin 100 mg. in 500 cc. D5W
O2 D.C.d
O2 restarted
Ritalin 200 mg. in 500 cc. of N/S
O2 D.C.d
Gastric lavage and nasal O2
Ritalin 90 mg. I.V.
Ritalin 100 mg. I.V.
Ritalin 60 mg. I.V.
BP dropped to 88/60
0 1 2 3 4 5 6 7 8 9 10 11
Hours

Fig. 3. Case 7. Treatment of thorazine-Mebaral depression. This graph represents the constant need for "titering" the dosage of Ritalin in severe cases.

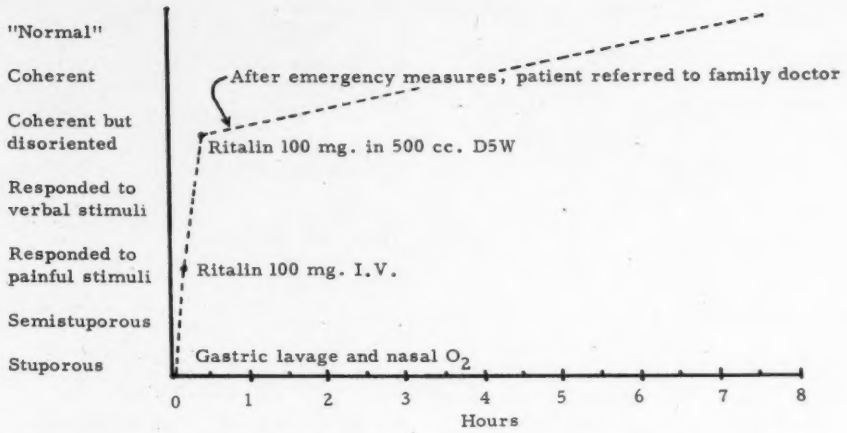

Fig. 4. Case 8. Treatment after Tolserol and an unknown tranquilizer. This represents an "average" case of attempted suicide.

Discussion of Cases

In an attempt to establish the clinical efficacy of Ritalin, it was decided to use the drug on patients suffering from severe central depression. Unfortunately, during the year of investigation, the etiology of the central depression was not varied as greatly as one would desire. Of the 7 patients in the original work, 5 had central depression from ethyl alcohol, 1 from isopropyl alcohol, and 1 from a combination of • chlorpromazine-barbiturate ingestion. The case presented in the addendum represents an overdosage of Tolserol and an unknown tranquilizer.

CASES 1 through 5.—These patients were all semistuporous to comatosed from excessive ethyl alcohol intake. Their cases are summarized in figure 1. The average blood pressure upon admission was 126/78; pulse 85. The greatest increase in systolic blood pressure was 38 mm. of mercury in a 77 year old man. The greatest diastolic rise was 20 mm. of mercury. The same patient had an increase in pulse rate of 34 after he became extremely excited (he received only 10 mg. of Ritalin).

CASE 6.—A 45 year old man was admitted to the hospital in an extremely comatosed state due to ingestion of isopropyl alcohol. This case is summarized in figure 2. Alcoholic content of the gastric content was 1.0 Gm. and the blood alcohol was 350 mg. per 100 cc. The patient required a large amount of Ritalin before responding in about 4 to 5 hours. All necessary roentgenograms, blood chemistries, and the spinal fluid were negative.

CASE 7.—A 23 year old man had ingested twelve 100 mg. Mebaral tablets and twenty-five 50 mg. thorazine tablets. His case is summarized in figure 3. The patient required large and frequent doses of Ritalin. The curve representing the level of consciousness indicates the need for close observation of this type case and the method of "titering" the Ritalin dosage.

Summary

Ritalin is an invaluable drug in the armamentarium for the treatment of the patient suffering from an overdose of central depressants. The return to an adequate level of consciousness is more rapidly obtained, the level being directly related to the interval and amount of Ritalin given. In this series, the vital signs were altered in only 2 persons. There was a 38 mm. of mercury rise in the systolic blood pressure in a 77 year old patient who had received 10 mg. of Ritalin intravenously, and an intravenous infusion of 1,000 cc. D5W with 90 mg. of Ritalin was started after a gastric lavage. This rise in blood pressure was approximately 1 hour after the medication was started and the patient was returning to a level of consciousness to verbalize his wishes. There was a diastolic blood pressure rise of 20 mm. of mercury and a pulse rate increase of 34 in 1 patient who had received 10 mg. of Ritalin and had become extremely excited. There were no other side effects noted, and the degree of transient hypertension was not as great as Hartert[4] noted.

The patients suffering from alcohol-induced depression required less Ritalin and responded more readily. The patient who ingested the isopropyl alcohol required more Ritalin and responded more slowly. The patient suffering from an overdose of barbiturate-thorazine required the most Ritalin and responded the slowest. It appears that better results are obtained by injecting large doses of Ritalin intravenously directly and undiluted when dealing with the latter 2 types of cases initially; then an intravenous "titer" can be established. The decreased blood pressure seen in case 7 appeared to respond

to Ritalin alone, whereas in the case reported by Ivey,[6] Ritalin was believed to potentiate the pressor effect of levo-arterenol bitartrate. (Blood pressure dropped to 88/60 some 4 hours after admission but stabilized at about 132/70 when the patient was completely alert.)

Conclusion

Ritalin has a useful place in the treatment of the comatosed patient. The usual steps for obtaining a definite history of the substances ingested and the ruling out of organic causes are essential. The amount of Ritalin required varies with the patient and is relatively easy to "titer in," but the attending physician or a highly competent person should observe the patient. It was found the drug-induced depression required 100 to 200 mg. of Ritalin initially and then a titer dose was instituted.

Addendum

Since the original work on this paper, an additional patient (case 8) has been treated with Ritalin. Her case is summarized in figure 4.

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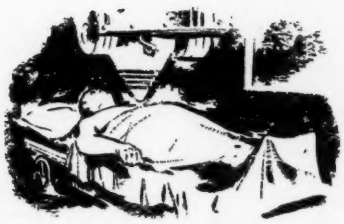

Present Status of Marrow Transplantation for Leukemia

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It has been established that lower animals can be protected by implantation of homologous hematopoietic tissue and that autologous tissue derived before irradiation is highly effective in protecting the radiated animal. This theory has been applied to the treatment of terminal leukemia patients. Results suggest that potentially lethal ranges of x-radiation followed by marrow autograft may be successful in treatment and eventual cure.

PRIOR TO the hypothecation that marrow drawn from a donor might be helpful in repopulating the diseased erythropoietic tissues of the leukemic patient, the bulk of the therapeusis rested upon antifolic acid compounds, inhibitors of purine and pyramidine synthesis, and the steroids. None of these techniques have been characterized by lasting success. However, chemical compounds frequently bring remissions and thereby enlarge the life span of the otherwise doomed individual.

Several years after Lorenz and others[11] demonstrated that intravenous bone marrow protected rodents against lethal x-radiation, Barnes and others[2] reported that intravenous infusions of isologous and homologous bone marrow successfully increased the survival in C.B.A. mice with lymphoid leukemia following a 100 per cent lethal dose of whole body x-radiation. With the event of Barnes' work, a new hope was given to leukemic patients, and the perfection of a new technique was immediately begun.

Naturally, no one at this time had substantiative evidence to back any hypothesis as to the mode of protection. However, it was assumed that "humoral factors" interacted in some fashion to modify the maleffects of the irradiation.[4] A more attractive theory was based upon the destruction of immunological response by the irradiation and subsequent repopulation of the marrow sites by the injected preparations. This would imply that leukemic marrow could be destroyed and that transplantation could be effected while the recipient's immunologic capacities are altered to such a degree that the donor marrow is not recognized as being foreign. The adaptation of the laboratory technique to man obviously required considerable experimentation.

Viable marrow cells may be easily procured from fetal and adult cadavers, from surgical specimens, and from biopsy specimens. The marrow is then infused into the patient who has been irradiated, and the erythropoietic material either thrives or the graft is rejected. Rekers[16] extensively studied the probable causes of failure of marrow grafts to develop in hosts. He considered causes such as inadequate stimulus for bone marrow growth, inadequate quantities of marrow, limited vascular supply to the implant, immunologic incompatibility, and embryologic age of the graft. Experimentation has ruled out the first three possibilities.[1] The problem of immunologic incompatibility, even when modified by x-radiation,

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may be a fundamental defect in the technique. Meighan and Bean[13] have considered that "the hemopoietic system in animals and man may be different and what may be applicable to disease and therapy in one is not in the other." Even if the graft procedure were successful, one must then ponder the possible delayed reactions due to either the transplant or the massive irradiation which made it possible.

Theoretical Concepts Of Transplantation

Lethal dosages of irradiation are followed by higher postirradiative survivals in animal groups given injected erythropoietic cellular material. The possibilities would be, as summarized from Torelli:[20]

1. Resumption of the hemopoietic process by repopulation.

2. Spontaneous regeneration of recipient's marrow made possible by the fact that marrow injections enabled the recipient to "tide over" the critical phase of aplasia.

3. Possible induction by injected marrow of a humoral factor capable of causing or stimulating medullary regeneration in the recipient.

Although the possibility that a humoral factor exists has never been completely ruled out, the preponderance of evidence presently supports the theory of repopulation. Several classical experiments indicate that various groups of researchers using different techniques all arrived at the same conclusions.

Lindsley and others[9] injected irradiated rats with a different "type" of marrow. They later demonstrated, using a differential agglutination with specific antiserum, that the circulating peripheral blood contained largely erythrocytes of the transplanted varieties.

Nowell and his group[14] showed that rat marrow injected into the mouse continues to function. Since polynucleated cells of the rat react strongly positive to the histochemical reaction for alkaline phosphatase, whereas the mouse does not, the demonstration of cells possessing the reaction within the mouse implies large numbers of rat cells living within the mouse.

Ford[6] demonstrated that irradiated mice which received cellular suspensions from donor mice having a specific chromosomal pattern began to produce cells which showed this chromosomal pattern.

Speculation as to the nature of which erythropoietic elements are the effective cell types indicts a dividing cell, which implies the stem cells and reticulum cells of hematopoietic tissue.[10] By necessity, it must be a cell which rapidly enters the blood-forming sites and becomes a blast cell; however, the exact types have not yet been determined.

Techniques

Marrow used for transplantation may have four origins:

1. Autologous—in which the recipient and the donor are the same animal.

2. Isologous—in which the recipient and the donor are of the same inbred strain (for example, mice).

3. Homologous—in which the recipient and the donor are the same species but vary as to strain or "genetic constitution" (for example, man).

4. Heterologous—in which species variation exists (for example, rat to mouse).

Needless to say, the probability of failure increases in descending order. Marrow is aspirated by multiple punctures of the iliac crests and sternum, usually done under anesthesia. The marrow is then placed in a tissue culture medium which contains heparin. The marrow suspension is cooled by Polge's method in 15 per cent glycerol with tissue culture solution to 70 C. and is stored for further use. The amount used for transplantation has been calculated by Thomas and others[19] to be about 4 to 40 billion nucleated marrow cells of the usual differential distribution. These figures were determined by results from mouse[3] and monkey[5] experiments.

To reduce the hazards of pulmonary embolism or general vascular obstruction, filtration and subsequent centrifugation are used to eliminate fat particles, spicules of bone, and small clots.

For obvious reasons, the LD^{50} for x-radiation delivered to man is not known. Accidental exposure and data from atomic blast survivors place the dose within 300 to 450 r.[15] The patient receives a dose of 450 to 550 rads of minimal midplane tissue x-radiation.

While the patient is being irradiated, the marrow is rapidly thawed in a water bath, and the infusion is started within the first postirradiation hour. The heparin which accompanies the infusion is neutralized by intravenous protamine sulfate. Early toxic manifestations may be demonstrated, such as anorexia, loss of weight, or epilation, and these signs may reverse or a progressive downhill course may supervene, demonstrating the severe toxic signs of massive irradiation, culminating in a rapid death. Autopsy findings resemble in many respects those described by Liebow and others in the Japanese victims of the atom bomb, dying about the same length of time after exposure.[3, 12]

Conclusion

It has been established beyond doubt that lower animals, especially rodents, can be protected by implantation of homologous hematopoietic tissue.[7, 11] It also has been shown that autologous tissue derived before irradiation is highly effective in protecting the radiated animal.[1] Since the radiation dose is able at least temporarily to disrupt the organism's immunologic mechanisms, it appeared quite feasible to apply this to cancer problems in which a large, diffuse type of malignancy which is totally radiosensitive may be destroyed. Since the most dangerous problems are associated with the loss of blood-forming elements, that is, overwhelming infections due to leukopenia and hemorrhagic episodes in the presence of thrombocytopenia, replacement of erythropoietic elements have been attempted. Direct application of this theory has been attempted in the treatment of terminal leukemia patients.

McGovern and others[12] and Meighan and Bean[13] have reported recently their experiences in 4 cases. Repplenger and others[17] presented 8 cases; however, disease persisted in 4 of 8 leukemic patients who survived after exposure to 300 r. Kurnick and others[8] have presented 2 cases of their unsuccessful experience of applying this technique to metastatic malignancies, and Thomas and others[18, 19] have presented 8 cases. Two of the cases involved twins. In the identical twin marrow autograft was deemed successful and the disease was in remission 67 days at the time of presentation of the paper. In the fraternal twin case, the patient was subjected to the procedure, and leukemia returned in 2 months. Subsequent repetition of the procedure has been done, and the disease has been in remission 1 month. Of this group, McGovern presented 1 successfully treated patient with acute lymphoblastic leukemia who was prepared during a period of remission induced by 6-mercaptopurine by removal and storage of marrow from the iliac crests. Following total body irradiation, she was given an autologous marrow infusion. The patient suffered minimal side effects, and 3 weeks postirradiation she showed no hematologic evidence of leukemia and has remained essentially "normal" for 4 months, at which time the case was published. This suggests that potentially lethal ranges of x-radiation followed by marrow autograft may be successful and thereby afford new insights in treatment, and eventually cures, of the diseases which classically terminate fatally.

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MEDICAL NEWS

★ Coming Meetings

Texas Medical Association, Galveston, April 22-25, 1961. Dr. May Owen, Fort Worth, Pres.; Mr. C. Lincoln Williston, 1801 North Lamar Blvd., Austin, Exec. Secy.

American Medical Association, Miami Beach, June 13-17, 1960. Dr. Louis M. Orr, Orlando, Fla., Pres.; Dr. F. J. L. Blasingame, 535 North Dearborn, Chicago 10, Exec. Vice-Pres.

Current Meetings

MAY

American Association for Thoracic Surgery, Miami Beach, May 11-13, 1960. Dr. William E. Adams, Chicago, Pres.; Dr. Hiram T. Langston, 7730 Corondelet Ave., St. Louis 5, Secy.

American Association of Genito-Urinary Surgeons, Dearborn, Mich., May 11-13, 1960. Dr. Reed M. Nesbitt, Ann Arbor, Mich., Pres.; Dr. W. J. Engel, 2020 E. 93rd St., Cleveland 6, Secy.

American Association of Plastic Surgeons, Milwaukee, May 17-20, 1960. Dr. Lyndon A. Peer, New Jersey, Pres.; Dr. Thomas D. Cronin, 6615 Travis St., Houston 25, Secy.

American Gynecological Society, Williamsburg, Va., May 30-June 1, 1960. Dr. Karl H. Martzloff, Portland, Pres.; Dr. A. A. Marchetti, 3800 Reservoir Rd. N.W., Washington 7, D. C., Secy.

American Ophthalmological Society, Colorado Springs, May 16-18, 1960. Dr. A. B. Reese, New York, Pres.; Dr. M. C. Wheeler, 30 W. 59th, New York 19, Secy.

American Orthopaedic Association, Hot Springs, Va., May 30-June 2, 1960. Dr. John Royal Moore, Philadelphia, Pres.; Dr. Lee Ramsay Straub, 535 East 70th St., New York 21, Secy.

American Pediatric Society, Swampscott, Mass., May 5-6, 1960. Dr. Samuel Z. Levine, New York, Pres.; Dr. A. C. McGuinness, Room 1036, 2800 Quebec St., N.W., Washington 8, D. C., Secy.

American Psychiatric Association, Atlantic City, N. J., May 9-13, 1960. Dr. William Malamud, New York, Pres.; Dr. C. H. Hardin Branch, 156 Westminister Ave., Salt Lake City, Secy.

American Urological Association, Chicago, May 16-19, 1960. Dr. William M. Coppridge, Durham, N. C., Pres.; Mr. William P. Didusch, 1120 N. Charles St., Baltimore 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Rome, Italy, May 15-18, 1960. Dr. Henry Meyerding, Rochester, Minn., Pres.; Dr. Ross T. McIntire, 1516 Lake Shore Dr., Chicago, Executive Director.

National Tuberculosis Association, Los Angeles, May 15-20, 1960. Dr. H. McLeod Riggins, New York, Pres.; Mrs. Wallace B. White, 651 Marlborough Rd., Brooklyn, Secy.

Texas Division, American Cancer Society, Austin, May 4, 1960. Dr. David A. Todd, San Antonio, Pres.; Mr. Curt W. Reimann, 5014 Bull Creek Rd., Austin 3, Executive Director.

Texas Hospital Association, Dallas, May 10-12, 1960. Mr. F. S. Walters, Jr., Amarillo, Pres.; Mr. O. Ray Hurst, 2208 Main, Dallas, Executive Director.

Fourth District Society, San Angelo, May 7, 1960. Dr. S. Braswell Locker, Brownwood, Pres.; Dr. J. G. Bodenhamer, Mason, Secy.

JUNE

American College of Chest Physicians, Miami Beach, Fla., June 8-12, 1960. Dr. Seymour M. Farber, San Francisco, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut, Chicago 11, Executive Director.

American Neurological Association, Boston, June 13-15, 1960. Dr. Derek Denny-Brown, Boston, Pres.; Dr. Melvin D. Yahr, New York Neurological Institute, 710 W. 168th Street, New York 32, Secy.

Texas State Board of Medical Examiners, Fort Worth, June 20-22, 1960. Dr. M. H. Crabb, Fort Worth, Secy.; Mrs. Carolyn H. Millard, 1714 Medical Arts Bldg., Fort Worth, Assistant Secy.

National and Regional

American Academy of Allergy, Washington, D. C. Dr. Bram Rose, Montreal, Canada, Pres.; Dr. Joseph Noah, 100 N. Euclid Ave., St. Louis 8, Mo., Secy.

American Academy of General Practice, Miami, April 17-20, 1961. Dr. John G. Walsh, Sacramento, Calif., Pres.; Mr. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Executive Secy.

American Academy of Pediatrics. Dr. William W. Belford, San Diego, Calif., Pres.; Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., Executive Director.

American College of Allergists, Dallas, March 12-17, 1961. Dr. Giles A. Koelsche, Rochester, Minn., Pres.; Mr. Eloi Bauers, 2160 Rand Tower, Minneapolis, Executive Vice-Pres.

American Academy of Dermatology and Syphilology, Chicago, Dec. 3-8, 1960. Dr. Francis W. Lynch, St. Paul, Minn., Pres.; Dr. Robert R. Kierland, Mayo Clinic, Rochester, Minn., Secy.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 9-14, 1960. Dr. John H. Dunnington, New York, Pres.; Dr. W. L. Benedict, 15 Second St. S.W., Rochester, Minn., Secy.

American Association for Maternal and Infant Health. Dr. M. Edward Davis, Chicago, Pres.; Mrs. Patricia Dorr, 116 S. Michigan Ave., Chicago 3, Executive Director.

American Association of Obstetricians and Gynecologists, Hot Springs, Va., Sept. 8-10, 1960. Dr. Robert A. Ross, Chapel Hill, N. C., Pres.; Dr. Clytle L. Randall, 216 Summer St., Buffalo 22, Secy.

American Cancer Society, New York, Oct. 26-27, 1960. Dr. Warren H. Cole, Chicago, Pres.; Mr. Granville Whittlesey, 521 West 57th St., New York 19, Secy.

American College of Gastroenterology, Philadelphia, Oct. 23-29, 1960. Dr. Joseph Shaiken, Milwaukee, Pres.; Mr. Daniel Weiss, 33 West 60th, New York 23, Executive Director.

American College of Obstetricians and Gynecologists. Dr. John I. Brewer, Chicago, Pres.; Mr. Donald F. Richardson, P. O. Box 749, Chicago 90, Executive Secy.

American College of Physicians. Dr. Howard P. Lewis, Portland, Ore., Pres.; Mr. E. R. Loveland, 4200 Pine, Philadelphia 4, Secy.

American College of Radiology, Atlantic City, Sept. 30-Oct. 1, 1960. Dr. Earl E. Barth, Chicago, Pres.; Mr. W. C. Stronach, 20 N. Wacker Dr., Chicago 6, Executive Director.

American College of Surgeons, San Francisco, Oct. 10-14, 1960. Dr. Owen H. Wangensteen, Minneapolis, Pres.; Dr. William E. Adams, 950 E. 59th St., Chicago, Secy.

American Congress of Physical Medicine and Rehabilitation, Washington, D.C., Aug. 21-26, 1960. Dr. F. J. Kottke, Minneapolis, Pres.; Dorothea C. Augustin, 30 N. Michigan Ave., Chicago 2, Executive Secy.

American Dermatological Association. Dr. Marion B. Sulzberger, New York, Pres.; Dr. Wiley M. Sams, 308 Ingraham Bldg., Miami 32, Secy.

American Gastroenterological Association. Dr. H. Marvin Pollard, Ann Arbor, Pres.; Dr. Wade Volwiler, University of Washington School of Medicine, Seattle 5, Secy.

American Heart Association, St. Louis, Oct. 21-25, 1961. Dr. A. Carlton Ernstene, Cleveland, Pres.; Mr. William F. McGlone, 44 E. 23rd, New York 10, Secy.

American Hospital Association, San Francisco, Aug. 29-Sept. 1, 1960. Dr. Russell A. Nelson, Baltimore, Md., Pres.; Dr. Edwin L. Crosby, 18 E. Division Street, Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Lake Placid Club, May 23-25, 1960. Dr. Fletcher D. Woodward, Charlottesville, Va., Pres.; Dr. C. S. Nash, 708 Medical Arts Bldg., Rochester, N. Y., Secy.

American Proctologic Society. Dr. H. R. Reichman, Salt Lake City, Pres.; Dr. Norman D. Nigro, 10 Peterboro, Detroit 1, Secy.

American Public Health Association, San Francisco, Oct. 31-Nov. 4, 1960. Dr. Malcolm H. Merrill, Berkeley, Calif., Pres.; Dr. Berwyn F. Mattison, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, New York, Oct. 2-7, 1960. Dr. J. Earl Remlinger, Jr., Wilmette, Ill., Pres.; Dr. Robert L. Patterson, 612 Bershire Drive, Pittsburgh 15, Secy.

American Surgical Association, White Sulphur Springs, W. Va., April 3-6, 1960. Dr. Warren H. Cole, Chicago, Pres.; Dr. William Altemeier, Cincinnati General Hospital, Cincinnati 29, Secy.

American Society of Clinical Pathologists, Chicago, Sept. 24-Oct. 2, 1960. Dr. John J. Clemmer, Albany, Pres.; Mr. Claude E. Wells, 445 Lake Shore Drive, Chicago 11, Executive Secy.

Association of American Physicians and Surgeons, St. Louis, Sept. 29-Oct. 1, 1960. Dr. Louis Wegryn, Elizabeth, N. J., Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Director.

Radiological Society of North America, Cincinnati, Ohio, Dec. 4-9, 1960. Dr. Lawrence L. Robbins, Boston, Pres.; Dr. Donald S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

South Central Association of Blood Banks. Dr. John B. Alsever, Phoenix, Pres.; L. Ruth Guy, Ph.D., Room 1101, Stoneleigh Hotel, Dallas, Secy.

Southern Medical Association, St. Louis, Oct. 31-Nov. 3, 1960. Dr. Edwin H. Lawson, New Orleans, Pres.; Mr. Robert F. Butts, 2601 Highland Ave., Birmingham 5, Ala., Executive Secy.

Southern Psychiatric Association, Virginia Beach, Va., Oct. 2-4, 1960. Dr. David A. Wilson, Charlottesville, Va., Pres.; Dr. Richard Proctor, Winston-Salem, N. C., Secy.

Southern Surgical Association, Boca Raton, Fla., Dec. 6-8, 1960. Dr. Francis Massie, Pres.; Dr. John D. Martin, Jr., Emory University, Ga., Secy.

Southwest Allergy Forum. Dr. Johnny A. Blue, Oklahoma City, Pres.; Dr. George L. Winn, Suite 104, Lister Medical Building, 430 Northwest Twelfth St., Oklahoma City, Secy.

Southwest Regional Cancer Conference, Fort Worth, Oct. 23, 1960. Dr. Robb Rutledge, Fort Worth, Chm.; Mrs. Ira Frances Ball, Westchester House, Fort Worth, Secy.

Southwestern Medical Association, El Paso, Oct. 20-22, 1960. Dr. R. L. Deter, El Paso, Pres.; Dr. Merle Thomas, 1501 Arizona Building, El Paso, Secy.

Southwestern Society of Nuclear Medicine, San Antonio. Dr. Peter E. Russo, Oklahoma City, Pres.; Dr. J. R. Maxfield, Jr., 2711 Oak Lawn Avenue, Dallas, Secy.

Southwestern Surgical Congress, Fort Smith, Ark. Dr. Fred H. Krock, Fort Smith, Ark., Pres.; Mary O'Leary, 813 Medical Arts Bldg., Oklahoma City, Exec. Secy.

Tri-State Medical Assembly, Louisiana, Sept. 14-15, 1960. Dr. R. B. Langford, Shreveport, Pres.; Dr. J. W. Wilson, Jr., 940 Margaret Place, Shreveport, Secy.

United States-Mexico Border Public Health Association. Mr. Frank J. Von Zuben, Jr., Austin, Pres.; Dr. Jorge Román, 243 United States Court House, El Paso, Secy.

State

Private Clinics and Hospitals, Dallas, December, 1960. Dr. Vance Terrell, Stephenville, Pres.; Mr. B. J. Warren, Deaton Hospital, Galena Park, Secy.

Texas Academy of General Practice, Dallas, Oct. 3-5, 1960. Dr. E. Sinks McLarty, Galveston, Pres.; Mr. Donald C. Jackson, 1905 N. Lamar, Austin, Executive Secy.

Texas Academy of Internal Medicine. Dr. Merton M. Minter, San Antonio, Pres.; Dr. Hugo T. Engelhardt, 1216 Main, Houston, Secy. Meetings restricted to members.

Texas Air-Medics Association, Galveston, April 22-25, 1961. Dr. C. D. Henry, San Antonio, Pres.; Dr. C. F. Miller, Box 1338, Waco, Secy.

Texas Association for Mental Health, Galveston, 1961. Mr. William R. Ransone, Dallas, Pres.; Mrs. Lawrence Marcus, 3525 Arrowhead Drive, Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, Feb. 10-11, 1961. Dr. Oran V. Prejean, Dallas, Pres.; Dr. Hugh W. Savage, 815 Fifth Ave., Fort Worth, Secy.

Texas Association of Public Health Physicians, Galveston, April 22-25, 1961. Dr. L. P. Walter, Austin, Pres.; Dr. W. V. Bradshaw, Jr., 1800 University Drive, Fort Worth, Secy.

Texas Club of Internists. Dr. W. W. Bondurant, Jr., San Antonio, Pres.; Dr. T. Haynes Harvill, Medical Arts Building, Dallas 1, Secy.

Texas Chapter, American Academy of Pediatrics, Galveston, April 22-25, 1961. Dr. J. T. Bennett, El Paso, Pres.; Dr. W. W. Kelton, Jr., 108 West 30th, Austin, Secy.

Texas Chapter, American College of Chest Physicians, Galveston, April 22-25, 1961. Dr. Hiram M. Anderson, San Angelo, Pres.; Dr. Milton V. Davis, 3707 Gaston Avenue, Dallas, Secy.-Treas.

Texas Dermatological Society, Galveston, April 22-25, 1961. Dr. M. W. Harrison, Houston, Pres.; Dr. D. Shelton Blair, 1609 Medical Arts Building, Dallas, Secy.-Treas.

Texas Diabetes Association, Galveston, April 22-25, 1961. Dr. James A. Greene, Houston, Pres.; Dr. John W. Chriss, 2436 Morgan Street, Corpus Christi, Secy.-Treas.

Texas Heart Association, Dallas, Sept. 9-10, 1960. Dr. Robert E. Leslie, El Campo, Pres.; Mr. Ernest T. Guy, 404 Jesse H. Jones Library Building, Houston 25, Executive Director.

Texas Industrial Medical Association, Galveston, April 22-25, 1961. Dr. Noble B. Daniel, Texarkana, Pres.; Dr. J. G. Burdick, Pasadena, Secy.

Texas Neuropsychiatric Association, Galveston, April 22-25, 1961. Dr. Clarence S. Hoekstra, Dallas, Pres.; Dr. E. Ivan Bruce, Jr., Galveston, Secy.-Treas.

Texas Ophthalmological Association, Galveston, April 22-25, 1961. Dr. Otto Lippmann, Austin, Pres.; Dr. James H. Scruggs, Waco, Secy.

Texas Orthopedic Association, Galveston, April 22-25, 1961. Dr. Ike S. McReynolds, Houston, Pres.; Dr. Margaret Watkins, Dallas, Secy.-Treas.

Texas Otolaryngological Association, Galveston, April 22-25, 1961. Dr. August J. Streit, Amarillo, Pres.; Dr. Louis E. Adin, Jr., Dallas, Secy.

Texas Pediatric Society, October, 1960, Dallas. Dr. Byron York, Houston, Pres.; Dr. C. E. Gilmore, 811 Bonham, Paris, Secy.

Texas Physical Medicine and Rehabilitation Society, Galveston, April 22-25, 1961. Dr. Edward M. Krusen, Dallas, Pres.; Dr. Oscar Selke, Medical Professional Building, Houston, Secy.

Texas Proctologic Society, Houston, February, 1961. Dr. J. Wade Harris, Houston, Pres.; Dr. H. Gray Carter, 915 St. Joseph St., Dallas, Secy.

Texas Public Health Association, Fort Worth, March 5-8, 1961. Mrs. Maggie Belle Davis, Corpus Christi, Pres.; Mr. Joseph N. Murphy, Jr., Box 4012, Austin 51, Executive Secy.

Texas Radiological Society, Fort Worth, Jan. 20-21, 1961. Dr. Delphin von Briesen, El Paso, Pres.; Dr. R. P. O'Bannon, 1216 Pennsylvania, Fort Worth, Secy.

Texas Rheumatism Association, Dallas, Dec. 9, 1960. Dr. Howard C. Coggeshall, Dallas, Pres.; Dr. J. Morris Horn, 3707 Gaston, Dallas, Secy.

Texas Society of Anesthesiologists, Galveston, April 22-25, 1961. Dr. Randle J. Brady, Houston, Pres.; Dr. Eugene L. Slataper, Houston, Secy.

Texas Society of Athletic Team Physicians, Galveston, April 22-25, 1961. Dr. W. S. Horn, Jr., Fort Worth, Pres.; Dr. Louis Levy, Fort Worth, Secy.-Treas.

Texas Society of Gastroenterologists and Proctologists, Galveston, April 22-25, 1961. Dr. H. Gray Carter, Dallas, Pres.; Dr. A. C. Broders, Jr., Temple, Secy.-Treas.

Texas Society of Pathologists, Inc., Galveston, April 22-25, 1961. Dr. O. J. Wollenman, Jr., Fort Worth, Pres.; Dr. Vernie A. Stembridge, Dallas, Secy.-Treas.

Texas Society of Plastic Surgeons, Galveston, April 22-25, 1961. Dr. J. B. Patterson, Fort Worth, Pres.; Dr. Raymond O. Brauer, Houston, Secy.-Treas.

Texas Society on Aging. Dr. Ernest W. Keil, Temple, Pres;. Mrs. William B. Ruggles, 3701 Stratford, Dallas, Secy.-Treas.

Texas Surgical Society, San Antonio, Oct. 3-4, 1960. Dr. Robert Wilson Crosthwait, Waco, Pres.; Dr. G. V. Brindley, Jr., Scott and White Clinic, Temple, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 2-3, 1960. Dr. Lyle J. Logue, Houston, Pres.; Dr. Oliver Suehs, 14 Medical Arts Square, Austin, Secy.

Texas Traumatic Surgical Society, Galveston, April 22-25, 1961. Dr. Edward R. Rowe, Galveston, Pres.; Dr. John C. Long, Plainview, Secy.-Treas.

Texas Tuberculosis Association, Corpus Christi, March 16-18, 1961. Dr. J. Edward Johnson, Pres.; Miss Pansy Nichols, P. O. Box 6158, Austin 21, Executive Director.

Texas Urological Society, Wichita Falls, January 21-22, 1961. Dr. Joseph Mitchell, Dallas, Pres.; Dr. O. C. Berg, 1300 8th St., Wichita Falls, Secy.

District

First District Society. Dr. Russell Holt, El Paso, Pres.; Dr. Gordon L. Black, 1501 Arizona St., El Paso, Secy.

Second District Society, Snyder, 1961. Dr. M. J. Loring, Midland, Pres.; W. S. Parks, Jr., 2009 W. Wall, Midland, Secy.

Third Ditrict Society, Lubbock. Dr. Grady M. Wallace, Lubbock, Pres.; Dr. H. Fred Johnson, 2308 W. Eighth, Amarillo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 8-9, 1960. Dr. John W. Chriss, Pres.; Dr. James Gabbard, 1001 Louisiana, Corpus Christi, Secy.

Seventh District Society. Dr. Robert N. Snider, Austin, Pres.; Dr. Richard Lucas, 502 W. 13th, Austin, Secy.

Eighth District Society, Corpus Christi, July 8-9, 1960. Dr. M. Warren Hardwick, Angleton, Pres.; Dr. J. L. Coleman, Box 3346, Victoria, Secy.

Ninth District Society, Bellville, Spring, 1961. Dr. Irving M. Watson, Jr., Conroe; Dr. William E. Sharp, 721 E. Texas, Baytown, Secy.

Tenth District Society, September, 1960. Dr. J. W. McCall, Jr., Beaumont, Pres.; Dr. Irving M. Richman, 3280 Fannin St., Beaumont, Secy.

Eleventh District Society. Dr. Ben Wilson, Tyler, Pres.; Dr. Floyd Verheyden, 813 John St., Jacksonville, Secy.

Twelfth District Society, Waco, January, 1961. Dr. Bernard Rosen, Corsicana, Pres.; Dr. R. L. Campbell, 205 S. 15th, Corsicana, Secy.

Thirteenth District Society, Fort Worth, Fall, 1960. Dr. William B. Allensworth, Mineral Wells, Pres.; Dr. R. D. Moreton, 1217 W. Cannon, Fort Worth, Secy.

Fifteenth District Society. Dr. Charles Wise, Naples, Pres.; Dr. George Bennett, 402 S. Bolivar, Marshall, Secy.

Clinics

Blackford Memorial Cancer Lectures, Denison, Nov. 11, 1960. Dr. Andrew Jackson, Denison, Chm.

Dallas Southern Clinical Society Conference, Dallas, March 20-22, 1961. Dr. Frank H. Kidd, Jr., Dallas, Pres.; Millard J. Heath, 433 Medical Arts Bldg., Dallas 1, Executive Officer.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 23-25, 1961. Dr. Max E. Johnson, San Antonio, Pres.; S. E. Cockrell, 202 W. French Place, San Antonio, Exec. Secy.
New Orleans Graduate Medical Assembly, New Orleans, March 6-9, 1961. Dr. Maurice E. St. Martin, New Orleans, Pres.; Mrs. Irma B. Sherwood, 430 Tulane Ave., New Orleans 12, Executive Secy.
North Texas-Southern Oklahoma Fall Clinical Conference. Dr. Frank J. Lee, 1300 8th, Wichita Falls, Chm.
Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 24-26, 1960. Dr. Vernon D. Cushing, Oklahoma City, Pres.; Miss Alma F. O'Donnell, 503 Medical Arts Bldg., Oklahoma City 2, Executive Secy.
Postgraduate Medical Assembly of South Texas, Houston, July 18-20, 1960. Dr. C. Alsworth Calhoun, Houston, Pres.; Mrs. W. H. Dahme, 412 Jesse H. Jones Library Bldg., Houston 25, Exec. Secy.

Board Examinations

Texas State Board of Examiners in Basic Sciences, Austin, Houston, Galveston and Dallas. Henry B. Hardt, Ph.D., Fort Worth, Pres.; Mrs. Betty J. Anderson, Chief Clerk, State Office Bldg., 201 E. 14th St., Austin.

EDUCATION

One Texan Among Lederle Grant Awardees

One Texas physician, Dr. George L. Jordan, Jr., of Baylor University College of Medicine, Houston, is among 14 young medical school faculty members who have been named this year to share $250,000 under the Medical Faculty Awards program of Lederle Laboratories Division, American Cyanamid Company.

In the 7 year span of the grants, more than $1,750,000 has gone to 105 faculty members in 55 United States and Canadian medical schools. Generally awarded for terms not to exceed 3 years, the money may be used in three ways: to supplement salary of an individual so that the school can retain him for vital teaching and research functions; to bring into a school a new faculty member not previously supported either by budget or research funds; or to continue the salary of an individual previously supported from sources outside the medical school, such as research fellowships or grants.

Nominations are made to the Awards Committee through the offices of deans of the medical schools.

Postgraduate Courses

Arthritis and Related Diseases, Hollywood-by-the-Sea, Fla., June 11-12.—Being held immediately following the annual meeting of the American Rheumatism Association and immediately preceding the annual meeting of the American Medical Association, this postgraduate seminar is acceptable for 8 hours of category I credit by the Academy of General Practice. It is sponsored by the Florida Chapter, Arthritis and Rheumatism Foundation, with the cooperation of University of Florida Medical College, University of Miami Medical School, Florida State Board of Health, and the South Florida Rheumatism Society. Registration fee is $15. Programs and registration forms are available from the Seminar Committee, Florida Chapter, Arthritis and Rheumatism Foundation, 1206 Huntington Medical Building, Miami 32, Fla.

Maternal-Fetal Relationships, Denver, June 27-29.—A summer seminar on "Basic Aspects of Maternal-Fetal Relationships" will be held June 27-29 in Denver. It is sponsored by the Department of Obstetrics and Gynecology of the University of Colorado School of Medicine. Tuition fee is $35 for the 3 days. This course is approved for American Academy of General Practice category I credit for 12 hours. For further information, those interested may write to the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20.

Internal Ophthalmology, Aspen, Colo., July 5-8.—A course in internal ophthalmology will be presented July 5-8 at Aspen, Colo. It is sponsored by the Colorado Ophthalmological Society and the Division of Ophthalmology of the Department of Surgery of the University of Colorado School of Medicine. The course has been arranged so that all scientific sessions will be held in the mornings, leaving the afternoons free for recreation. Registration fee for the course is $50. Those interested in further information may write the Office of Postgraduate Medical Education at the University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20.

Five More Schools Approved For Vocational Nurse Training

Five schools have been newly added to those in Texas offering vocational nurse training programs, bringing the total to 108, F. R. Higginbotham, president of the Board of Vocational Nurse Examiners, has announced. The new training centers are Refugio County Hospital, Refugio; Victoria College, Victoria; Big Sandy Hospital, Big Sandy; Bethania Hospital, Wichita Falls; and Lamesa School of Vocational Nursing, Lamesa.

At the March 25 statewide examination, 589 candidates passed and were issued vocational nursing licenses. Highest score on the examination (94.8) was attained by Mrs. Elizabeth Duncan Coke, who completed her year's training at Memorial Hospital School of Vocational Nursing, Mt. Pleasant.

Since inception of the Vocational Nurse Law in 1951, a total of 21,853 licenses have been issued, including those to licentiates qualified through waiver requirements, those who qualified through schooling and examination, and those whose licenses were issued by reciprocity.

Next state board examination will be held July 23 in Austin, with deadline for applications submission June 22. Governor Price Daniel appointed the following on March 14 to serve 6 year terms on the board of examiners: Mrs. Lena Mae Land, R.N., Brady; Mrs. Willie B. Robichaux, L.V.N., Beaumont; and Mrs. Winnie O. Warhol, L.V.N., Marlin.

Houston Symposium to Study Mental Retardation Set June 2-4

"Causes of Mental Retardation and Practical Approach to Diagnosis and Management" will be the subject of a postgraduate symposium to be held June 2-4 in the auditorium of the Texas Children's Hospital, Houston.

The symposium is being presented under auspices of the Department of Pediatrics, Baylor University College of Medicine, and the Division of Maternal and Child Health, State Department of Health. Making arrangements are Dr. Russell J. Blattner, Texas Children's Hospital physician-in-chief and chairman of the Baylor Department of Pediatrics, and Dr. A. Aaron Mintz, chairman of the postgraduate teaching committee, Baylor Department of Pediatrics.

Medical Students' Day Held at Baylor University, Houston

The Texas Medical Association and Harris County Medical Society jointly honored medical students on April 28 with the annual Medical Students' Day at the Baylor University College of Medicine, Houston.

Dr. May Owen, Fort Worth, President of Texas Medical Association, presented the evening dinner address, climaxing the program. Her topic was "Looking Ahead: Healing, Teaching, Citizenship."

Dr. Wendell H. Hamrick of Houston, president of the Harris County Medical Society, presided at the one-day meeting and delivered the welcoming address.

Other speakers and their topics were C. Lincoln Williston, Austin, Executive Secretary of Texas Medical Association, "The Best Medical Care for All Texans"; Dr. Thomas L. Royce, Houston, member of the Council on Public Relations and Public Service, "Your Practice and Public Opinion"; Donald M. Anderson, Austin, Assistant Executive Secretary of the Association, "Serving the Doctors of Texas"; and Pat Bailey, Austin, Assistant General Counsel of TMA, "Legal Aspects of Medical Practice; Malpractice—How to Avoid It."

Also, Dr. R. Mayo Tenery, Waxahachie, District 14 Councilor, "Medical Ethics and Medical Etiquette; Obligation of the Physician to His Colleagues and to the Profession"; William L. Haverfield, Houston, Medical Center representative, Mead Johnson & Company, "Where Should I Practice?"; and Dr. Harvey Renger, Hallettsville, President-Elect of TMA, "The Business Side of Your Practice."

Dr. James H. Sammons of Highlands, District 9 Vice Councilor, presided over the evening and dinner session.

George Noon, president of the senior class of Baylor University College of Medicine, gave the student response and Dr. Stanley W. Olson, Houston, dean of the medical college, responded for his office.

Dr. Herbert H. Duke of Baytown, District 9 Councilor, introduced the dinner speaker, Dr. Owen.

Physicians Still Needed by Armed Forces Despite Occasional Surplus: Hershey

The Armed Forces continue to require the services of most physicians liable for military service under the Universal Military Training and Service Act. Lt. General Lewis B. Hershey, director of Selective Service, issued this reminder to physicians when it became apparent recently that the Armed Forces would not call to active duty a small number of physicians in a few specialties who had been deferred for residency training under the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program.

All reserve officers deferred for residency in most specialties will be called.

The Selective Service director urged doctors not to draw erroneous conclusions concerning the need for their services. If a substantial number of physicians conclude they are not needed, existing shortages in the Armed Forces will be aggravated, he said. Temporary surpluses in some areas are due to such factors as 4-or-5-year-ahead planning, revisions in Armed Forces strength, redistribution of troops, reorganization of the hospital system, specialists choosing a military career, and voluntary extension of duty tours by reserve officers.

Two-Campus Route Developed For Degree in Nursing

An improved two-campus educational route to a bachelor of science degree in nursing at the University of Texas will be inaugurated with enrollment of the freshmen class in September, Dr. Logan Wilson, president, announced recently.

The first half of the student's 4 year term will be taught at the University's main campus in Austin and the second half in the school and hospitals of the Medical Branch in Galveston. A variation of the University's program allows for acceptance of a nursing student who has completed prescribed freshman work at any accredited junior or senior college. Applications for fall enrollment will be received at both Galveston and Austin immediately.

High lights of the program are (1) it will streamline the work, cutting out about 8 weeks of classroom time through rearranged schedules, allowing more vacation time and conforming with usual academic calendars; (2) several members of the Medical Branch faculty will shift to Austin to teach preparatory nursing courses in conjunction with other work in the College of Arts and Sciences; and (3) the curriculum will be strengthened by utilizing more of the main University's teaching faculty and facilities.

Foreign Study Grants Available to Medical Students

A program to further international relations for the United States by making it possible for medical students to serve as unofficial ambassadors, has been announced by the Association of American Medical Colleges and Smith Kline & French Pharmaceutical Company.

Established by a $180,000 grant from Smith Kline & French, the new program will provide foreign fellowships through which students of United States medical colleges may travel abroad for a limited period of time to work in remote areas of the world.

Any student who has completed his third year of medical school is eligible to apply for a fellowship. If accepted he may spend 12 weeks or more at a foreign mission or other remote private medical facility, or a public health unit, clinic, or hospital. Medical students who wish to apply for a fellowship must submit their application to the dean of their medical school. If the application is acceptable, the dean will then endorse it and forward it to the Association of American Medical Colleges.

University of Texas Medical Branch

Dr. Wilder Penfield, director of the Montreal Neurological Institute, and chairman of the Department of Neurology and Neurosurgery at McGill University, gave the Kempner Lecture at the University of Texas Medical Branch, April 28, in Galveston. He spoke on "The Record of Experience." "The Importance of Dreaming" was his subject for a lecture at the Medical Branch the next day.

Dr. Robert Pudenz of Pasadena, Calif., was speaker for the annual Greenwood Lecture at the University of Texas Medical Branch, Galveston, on March 8. His subject was "The Dynamic Aspects of Head Injury."

MEDICAL MEETINGS

Out-of-State Speakers, Workshops Set for Alcoholism Institute

A faculty of national repute will present latest authenticated information relating to the nature, treatment, and prevention of alcoholism when the University of Texas holds the third session of its annual Institute on Alcohol Studies June 26-29 in Austin.

"The Magnitude and Scope of the Problem" will be discussed by John Park Lee, executive secretary, Board of National Presbyterian Health and Welfare Association, United Presbyterian Church, USA, New York.

"Where Do We Go From Here?" will be the topic of Carl Anderson, Ph.D., alcoholism program services staff member, National Institute of Mental Health, Bethesda, Md.; and C. Stanley Clifton, Director of the School of Social Work, University of Oklahoma, Norman, will speak on "The Disintegrative Effects of Alcoholism on the Family."

George Moon of the Texas Company, Port Arthur, will discuss "Economic Aspects of Alcoholism in Industry," Dr. Earle M. Marsh of San Francisco will discuss "How One Becomes an Alcoholic and What Can Be Done About It," and Jessie Helen Haag, Ed.D., associate professor of health and education at the University of Texas, will speak on "An Effective Preventive for Alcoholism."

"Utilizing Community Resources in Attacking Alcoholism" will be the topic of Frances Robertson, executive director, Houston Council on Alcoholism, Houston.

Workshops for social workers, clergy, educators, physicians, nurses, correctional officials, and civic leaders are planned.

All sessions will be held in air-conditioned Kinsolving Dormitory on the University of Texas campus. Institute registration fee is $15, with a limited number of scholarships offered to Texas residents. Rates for room and board at Kinsolving Dormitory for the 3-day period are $21 twin bedroom, $27 single bedroom, with connecting baths. Registration of full-time students is limited to 200, special consideration being given to those in position to make greatest use of knowledge gained in the respective fields in which each is engaged.

Application blanks or information may be requested from the Texas Commission on Alcoholism, State Office Building, Austin.

Second Annual Cancer Conference Set for Oregon July 7-8

The second annual Oregon Cancer Conference is being held July 7-8 in Portland, under joint sponsorship of the Oregon State Medical Society, the Oregon Division of the American Cancer Society, and the University of Oregon Medical School.

Guest lecturers will include Dr. Oscar Creech, Jr., New Orleans, professor and chairman of the Department of Surgery, Tulane University School of Medicine; Dr. J. Hartwell Harrison, Boston, clinical professor of genitourinary surgery, Harvard Medical School; Dr. Henry Jaffe, Los Angeles, director of the Division of Radiation Therapy and Nuclear Medicine, Cedars of Lebanon Hospital; Dr. I. S. Ravdin, Philadelphia, professor of surgery at the University of Pennsylvania Medical School; and Dr. R. Wayne Rundles, Durham, N. C., Department of Medicine, Duke University Medical Center. Program chairman is Dr. Martin A. Howard, Portland.

Entire expense of the conference is being underwritten by the Oregon Division of the American Cancer Society; there will be a charge for luncheons and banquet. All sessions are to be at the new Sheraton Hotel, where a block of rooms has been reserved for physicians wishing to attend. Further information may be requested from Roscoe K. Miller, executive secretary, Oregon State Medical Society, 2164 SW Park Place, Portland 5.

International Internal Medicine Congress To Attract Top Men Around World

The Sixth International Congress of Internal Medicine, organized by the International Society of Internal Medicine, will be held August 24-27 in Basle, Switzerland. Some 70 leading internists from all over the world will take part in the main scientific program by reading papers or participating in panel discussions.

Official languages will be German, French, and English, with simultaneous translation. Principal subjects of the Congress are to be "Pathogenesy and Therapy in the Edema" and "Enzymic Regulations in the Clinic." Panels on interstitial nephritis, nephrosis, diuretics, diagnostic value of the enzymes, therapeutic indications of the enzymes, and serology in rheumatic diseases will be held. Also slated are instruction in internal medicine and lectures on subjects of free choice.

Programs and registration forms may be requested from Dr. H. Ludwig, Secretary of the Sixth International Congress of Internal Medicine, Steinentorstrasse 13, Basle 10, Switzerland. President of the congress is Dr. A. Gigon, Basle; president of the International Society, Sir Russell Brain, London.

Congenital Malformations to Be London Conference Topic

The International Conference on Congenital Malformations will be held in London July 18-22 under sponsorship of the National Foundation. Its program will deal particularly with the incidence of congenital malformations and their relationship to social and medical conditions, the genetic and environmental factors that may be responsible, the normal mechanisms of embryogenesis and the conditions which result in abnormalities, the relationships between mother and fetus during pregnancy, and the obstetrical problems related to deformity.

Further information may be requested from Stanley E. Henwood, executive secretary, International Medical Congress, Ltd., 120 Broadway, New York.

International Medical Assembly Of Southwest Texas Elects

The International Medical Assembly of Southwest Texas elected officers and directors for the 1961 meeting and a president-elect for its 1962 meeting when it held its annual business session February 29 in San Antonio.

New officers and directors include Dr. Max E. Johnson, president; Dr. Lawrence B. Reppert, president-elect; Dr. A. P. Thaddeus, first vice-president; Dr. John M. Smith, Jr., second vice-president; Dr. William M. Center, secretary-treasurer; Dr. John H. Bohmfalk, Dr. E. A. Maxwell, Dr. James L. Mims, Dr. John C. Parsons, Dr. James B. Pridgen, Dr. A. O. Severance, and Dr. H. Vincent Walker, directors, all of San Antonio.

Texas Rehabilitation Association Names Speakers for July 21-22 Meet

National rehabilitation experts in a variety of areas have been dated as speakers for the annual session of the Texas Rehabilitation Association, which will be held July 21-22 in the Baker Hotel in Dallas. Luncheon speaker will be Governor Price Daniel.

"Texas Considers Its Obligations to the Handicapped" will be the subject of Dr. Donald A. Covalt, director of the department of physical medicine and rehabilitation, New York College of Medicine, New York City.

Ben H. Mitchell, president of Texas Employers Insurance Association, will discuss "The Insurance Carriers Consider Their Obligation to the Handicapped Workman of Texas."

Moderator for a panel before the Association's insurance section will be W. Scott Allen, assistant vice-president of Liberty Mutual Insurance Company and author of the book, "Rehabilitation: A Community Challenge." A panelist is to be Justin Harris, director of the Rehabilitation Advisory Service, General Reinsurance Corporation.

The brace and prostheses group has secured as speakers Jerry Levy, vice-president of A. J. Hosmer and D. W. Dorrance Company, Santa Clara, Calif., who will discuss "Today's Upper Extremity Prostheses in Action"; Paul Ryckoff of the U. S. Manufacturing Company, Glendale, Calif., who will describe "The Hydra Cadence Knee Unit"; and Lester Smith, assistant director of AOPA, Washington, D. C., who will speak on "Aids in the Othotics and Prosthetic Field."

Slated for the afternoon session on July 21 is the meeting of the speech and hearing group. At this session, Dr. Marvin C. Culbertson, Jr., Dallas, will speak on "The Importance of Otological Examinations and the Stapes Mobilization Operation."

"Speech Problems with an Adult" will be the topic of Kennon H. Shank, Ph.D., associate professor in the department of speech, University of Oklahoma.

Frederick J. Artz, director of sales and field representative for Zenith Hearing Aid Corporation, Chicago, will speak on "The Importance of Fitting Hearing Aids." He was formerly director of the Speech and Hearing Clinic of Seattle.

World Medical Association U. S. Committee to Meet June 14

The fifth annual meeting of the United States Committee, World Medical Association, will be held Tuesday, June 14, at the Hotel Americana in Miami Beach during the American Medical Association session. The program is scheduled to begin at 3 p.m.

The fourteenth general assembly of the World Medical Association is set for September 15-22 in West Berlin, Germany.

Institute on Hospital Accounting

The sixth annual Institute on Hospital Accounting will be conducted by the Florida Chapter of the American Association of Hospital Accountants and the Florida Hospital Association, September 14-16, in Jacksonville, Fla. The theme of the institute is "Missile Age Accounting." For further information, those interested may write Raymond F. Poore, South Miami Hospital, South Miami, Fla.

Rocky Mountain Cancer Meet Scheduled July 20-21 in Denver

Dates for the fourteenth annual Rocky Mountain Cancer Conference will be July 20-21 in the new Denver-Hilton Hotel in Denver.

Tentative program plans for the conference, sponsored by the Colorado Division of the American Cancer Society and the Colorado State Medical Society, include a symposium on skin cancer and a symposium on thyroid lumps. Afternoon sessions on both days will be devoted to papers on cancer detection and treatment by six outstanding physicians.

Participants and speakers are Dr. R. Lee Clark, Jr., Houston; Dr. A. James French, Ann Arbor, Mich.; Dr. Roy L. Kile, Cincinnati; Dr. Wendell G. Scott, St. Louis; Dr. H. W. Schmidt, Rochester, Minn.; and Dr. Willard P. VanderLaan, La Jolla, Calif. Participating also in the conference will be Dr. E. Vincent Askey, Los Angeles, president-elect of the American Medical Association, and Dr. Warren H. Cole, Chicago, president of the American Cancer Society.

DRUG NOTES

New Nonmercurial Diuretic Drug Lacks Side Effects of Recent Compounds

BENZTHIAZIDE (Charles Pfizer & Co.) a new nonmercurial diuretic related to Chlorothiazide (Diuril, Merck-Sharpe and Dohme). A recent research paper reports outstanding pharmacological properties of this compound. Its close relationship to a well known group of diuretic agents prompted this brief resume.

In 1945, the discovery of the renal effect of inhibitors of this enzyme system as diuretics, stimulated research in this area that has led to a series of carbonic anhydrase inhibitors as diuretics (e.g. Acetazolamide, Diamox, Lederle). Although these compounds are effective diuretics, on the basis of their mechanism of action they give rise to a number of side-effects. Pharmacodynamically, this inhibition of carbonic anhydrase leads to diuresis by decreasing tubular reabsorption of bicarbonate, thus promoting excretion of bicarbonate ions which leads to loss of extracellular fluid. Generally, this is followed by depletion of bicarbonate and acidosis, which leads to side effects that limit the use of these carbonic anhydrase inhibitors.

Consequently, research has been directed towards the design and synthesis of a diuretic that would exhibit a higher degree of specificity and lack these side effects. These efforts have led to the synthesis of Chlorothiazide which has shown properties common to both the mercurial diuretics and the carbonic anhydrase inhibitors; it increases the renal excretion of sodium with an equivalent amount of chloride, and to a lesser degree the excretion of potassium and bicarbonate. Since structure-activity relationships indicate that the diuretic potency may be altered by structural modifications on the heterocyclic ring of the Chlorothiazide molecule, research efforts have led to this new diuretic, Benzthiazide. Benzthiazide has been investigated pharmacologically, and the data demonstrates that the introduction of a benzylthiomethyl group into position three of the heterocyclic ring conferred upon the molecule a pronounced increase in diuretic potency.

Benzthiazide is considered a highly potent and orally effective diuretic and saluretic. In comparison with cholorothiazide, it is reported to be 4 and 8 times more potent in dogs and rats, respectively. When compared with hydro-

chlorothiazide in rats, Benzthiazide was found to be 1.8 times more potent in its natriuretic effect.

NAQUA (Trichloromethiazide, Schering Corporation) is another relatively new diuretic bearing very close relationship to Chlorothiazide and Benzthiazide (mentioned previously). All three of these diuretics possess a common *sulfonamide-heterocyclic nucleous* as the major structural feature. Consequently, compounds possessing this nucleous are considered to be "benzothiadiazine" derivatives.

The available clinical data reveals certain outstanding structure-activity relationships. Naqua is reported to possess 10 to 20 times higher saluretic potency than Hydrochlorothiazide, and, correspondingly, 100 to 200 times that of Chlorothiazide. Naqua is also reported to exert a more prolonged duration of action than other benzothidiazine derivatives.

The mechanism of action by which Naqua effects diuresis is by an inhibitory effect on the reabsorption of sodium and chloride in the renal tubules, hence, exerting an increase in the rate of excretion of sodium and chloride. Its effect on potassium and bicarbonate is apparently only temporary and exerted only to a lesser degree. Therefore, in this respect this new diuretic exerts its activity on the basis of the same fundamental principle of the mechanism of action of the other benzothiadiazine derivatives, but, apparently exerts a more potent effect. Qualitatively, the activity should be considered similar, but very different from a quantitative standpoint.

LIBRIUM (Methaminodiazepexide, Hoffman - LaRoche, Inc.) is a new psychotherapeutic agent. This new compound is a member of a new chemical class of compounds, and furthermore, exhibits unusual pharmacological properties. Although it is difficult to estimate its eventual position in the armamentarium of the physician in the treatment of psychiatric disorders, the available clinical data indicates that Librium is a very interesting and valuable drug.

Although chemically different from the phenothiazines, reserpine and meprobamate, it is known to exert the tranquilizing effects of chlorpromazine (Thorazine, SKF) and reserpine (Serpasil, Ciba). On the other hand, Librium lacks the autonomic blocking effects of these compounds. Furthermore, it is considerably more potent than meprobamate (Equanil, Wyeth) in its muscle relaxant effect. In comparison with the barbiturates, Librium is known to exert anticonvulsant effects similar to those of phenobarbital, but does not induce hypnosis.

Pharmacological data reveals that Librium has a unique effect in taming monkeys at doses below the ataraxic dose. Comparative studies show that this taming effect was not observed with meprobamate, chlorpromazine, and phenobarbital until the ataraxic dose was reached. It has been postulated that this new psychopharmacologic agent has two different types of action, that is, an anti-anxiety effect and a sedative activity. On the basis of these two actions, Librium is considered by clinicians in psychiatry to be the most potent agent presently available in its ability to allay anxiety and tension in the presence of depression. Furthermore, it has been reported that this new product is believed to exert a psychostimulating effect which is manifested in a feeling of well being, increased social participation, and lifting of anxious depressions.

Librium is indicated whenever fear, anxiety, and tension are significant components in the clinical profile. In low doses (10 mg. 3 or 4 times daily) it is indicated in cases of mild to moderate anxiety and tension, preoperative and postoperative apprehension, premenstrual tension, and other gynecologic malfunctions. In higher doses (20 mg. three or four times daily) it is indicated in severe anxiety and tension, chronic alcoholism, agitated depression, and ambulatory psychoneuroses.

TETRABENAZINE (Nitoman, Hoffman-LaRoche) is another psychopharmacologic agent that has been recently developed. This new compound is a benzoquinolizine derivative. Although it is chemically different from Reserpine, an indole alkaloid, animal experiments indicate that the action of Tetrabenazine resembles Reserpine. Nevertheless, in spite of the fact that this new compound does not possess an indole nucleous, both compounds under consideration may be considered as containing the quinolizine nucleous. Consequently, like Reserpine, Nitoman is believed to release norepinephrine and serotonin in the brain since they possess a certain degree of similarity and may compete for the same receptor sites.

Tetrabenazine decreases the serotonin and norepinephrine values of the brain. In this respect it bears very close pharmacological properties to Reserpine. It has been reported that it differs from Reserpine in a number of respects: it is less potent; it is shorter acting; it exerts a selective action on the brain since it releases little or no serotonin and epinephrine peripherally; and it possesses the capability of blocking the action of Reserpine.

Clinical investigations reveal that this new product is effective in schizophrenic hallucinations. A comparison of Tetrabenazine, Reserpine, and Placebo reveals that 55 per cent of the patients (schizophrenic) treated with Tetrabenazine improved, whereas, 61 per cent of the patients treated with Reserpine showed improvement. Patients treated with Reserpine demonstrated improvement during the third month of treatment, those with Tetrabenazine showed the greatest clinical improvement in the first month.

—HERBERT SCHWARTZ, M.S., and
JAIME N. DELGADO, M.S., Austin.

MEDICOLEGAL NOTES

Instructions Given by Telephone Should Be Repeated to Doctor

Numerous times each day physicians find it necessary to converse with hospital personnel concerning the care and treatment to be given individual patients and to pharmacists in connection with prescriptions to be dispensed or delivered to a patient. Often, by virtue of necessity or convenience, this is done by telephone and the instructions given by the physician on these occasions are frequently of a nature which if not correctly understood could result in serious harm or injury to the patient involved.

Undoubtedly, every physician has at one time or another been personally aware of, or heard of, a situation where injury or harm was suffered by a patient or barely averted by telephoned instructions being incorrectly understood or interpreted. This invariably leads to the questions of where does the blame and potential liability rest if injury or harm is suffered by the patient, and what can be done to lessen the likelihood of such unfortunate incidents.

Let us first take, for an example, a case where a physician, by telephone, instructs certain hospital personnel to administer a particular drug to one of his patients. The nurse misunderstands the physician's instructions and subsequently the patient is given an incorrect drug which results in harm or injury to the patient. This invariably raises the question of whether the physician erroneously gave the wrong instructions or whether the nurse was in error in her understanding of the physician's order or instructions. This, in turn, can easily result in a "swearing match" as to who was in error—the physician or the nurse.

From a practical standpoint, should litigation result, the

effort will probably be made to place the responsibility for the error upon the physician. This is because, as a general rule, the physician will not have some of the defenses available that are available to the hospital, should the hospital be a party to the suit. The collection of a judgment once rendered for damages incurred by the patient from the physician rather than the nurse normally would tend to be more successful, because of the physician's likelihood of having insurance coverage or assets readily reached.

Next, let us take an example where the physician telephones a prescription to a pharmacist. Once again there is a misunderstanding as to the drug being prescribed or dosage and the patient subsequently receives the wrong drug or instructions and suffers injury or harm. Again, this raises the issue, in many instances, of who was at fault. Did the physician actually prescribe the wrong drug or did the pharmacist err in his understanding of the physician's instructions? In most instances, it could be anticipated that both the physician and the pharmacist would be sued, and it is conceivable that both might be found negligent due to their failure to take safeguards to prevent this type of occurrence.

This then raises the problem—what steps can be taken to guard against this type of unfortunate and, perhaps, costly incident? Although no procedure is or can be foolproof, I do feel that if the physicians would take one particular safeguard, this potentially dangerous type of occurrence would be substantially eliminated.

If the physician, once he has completed his instructions, orders, or prescriptions, would have the nurse at the hospital or the pharmacist repeat back to him the instructions, orders, or prescriptions he has given, it would serve as a check for both the physician, nurse, and pharmacist that the instructions or prescriptions have been understood and correctly so. The small amount of time that this procedure would take for all parties concerned would be more than offset by the loss of time which could be incurred by all in the event of litigation arising from an incident which might have been prevented.

—PHILIP R. OVERTON, LL.B., Austin.

OF GENERAL INTEREST

Personals

Dr. C. C. Pate, Paducah, known in Cottle and King Counties as the "white-haired country doctor," was honored in a surprise testimonial program at the annual Paducah Lions Club ladies' night banquet recently. High light of the occasion was the presentation of an oil portrait of Dr. Pate painted by Mrs. Charles Pearson, Paducah. A native of Ennis and Graduate of Vanderbilt University, Dr. Pate came to Paducah in 1926. He has been in the medical, civic, and religious activities of the community.

Dr. William S. MacComb, Houston radiation therapist, received the Janeway Medal from Dr. Theodore R. Miller, New York City, American Radium Society president, in ceremonies at the March 17-19 forty-second annual meeting of that organization in San Juan, Puerto Rico. Dr. MacComb had presented the society's annual Janeway Lecture, which memorializes pioneer contributions in radiation therapy by the late Dr. Henry Harrington Janeway.

Dr. George L. Jordan, Jr. of Houston presented a paper April 20 before the Third (Boston University) Surgical Service of Boston City Hospital entitled, "The Surgical Management of Acute Gastroduodenal Perforation."

The late *Dr. J. M. Frazier* of Belton was honored April 15 when his former pupils, college co-workers, fellow deacons, patients, and children gathered to dedicate the Frazier Memorial Health Center on the campus of Mary Hardin-Baylor College in Belton.

Dr. William C. Holt of Angleton was recognized March 30 on Doctor's Day by the Brazoria Woman's Auxiliary as the doctor who has practiced the longest in the county. He recently observed his thirtieth year there.

Dr. Nym L. (Bill) Barker, Paris general practitioner, was the subject of a "profile" sketch on the editorial page of the *Paris News* on March 27. Citing Dr. Barker for his civic and medical work, the article pointed to his recent appointment to Governor Daniel's Advisory Commission on Aging and his current presidency of the newly-formed United States Clubs of Paris.

Dr. Milton Turner, Austin physician and an Air Force Reserve lieutenant colonel, was among 76 doctors who were graduated from the primary course in aviation medicine at Brooks Air Force Base School of Aviation Medicine early in April. He drove a total of 8,100 miles between Austin and San Antonio over a period of 3 years to complete the course, points out an Air Force news release. While on active duty, Colonel Turner is assigned to the directorate of air crew effectiveness, headquarters, Air Training Command.

Mrs. W. F. McCreight, wife of the Kirbyville physician, died February 6, 1960, in a Beaumont hospital. A charter member of the Jasper-Newton Counties Medical Auxiliary who held numerous offices in the auxiliary, Mrs. McCreight was the daughter of Dr. and Mrs. David Scarborough of Alba. In addition to Dr. McCreight, she is survived by three children, Kathleen Inez Matthews, Channelview; William F. McCreight, Jr., Kirbyville; and Wanda Marie Brown, Crockett.

Congressional Funds Available For Community Cancer Projects

Funds appropriated by Congress for preventing and controlling cancer are now available for community cancer demonstration projects. Administered by the Cancer Control Program, Bureau of State Services of the Public Health Service, the program is under the technical guidance of the director of the National Cancer Institute.

Nine types of projects believed to offer the best opportunities for demonstrating better ways of providing community cancer control services include: (1) professional and technical education in cytology, (2) screening female beneficiaries of medical care for cancer of the cervix, (3) selected educational projects, particularly public information and follow-up services, to emphasize the importance of periodic uterine cytology examinations, (4) professional educational activities emphasizing the importance of including cancer diagnostic aids in complete health examinations, (5) selected public educational projects on the desirability of and need for health maintenance examinations, (6) evaluation of effectiveness of public educational activities, (7) tumor registers collecting data of exceptional value, (8) extension and evaluation of rehabilitation programs in cooperation with state rehabilitation agencies, and (9) selected projects demonstrating effective treatment for cancer in public beneficiaries of medical care.

Applications are accepted from nonprofit organizations, institutions, and official health agencies. Additional information and application forms may be obtained from the Department of Health, Education, and Welfare, Region VII, 1114 Commerce Street, Dallas 2.

Universal Distribution Makes Tuberculosis Control Difficult

Worldwide distribution of tuberculosis creates a formidable obstacle to its control, and makes its elimination extremely difficult.

Although the struggle in many countries is a battle primarily involving large numbers of people with open and active disease, attention in the United States is turning increasingly toward the nearly 50,000,000 people who have been infected and who react positively to intradermal tuberculin. These individuals constitute the source, current and future, of all cases of active infectious disease. Frequent and widespread use of the tuberculin test to identify these infected persons should be encouraged.

In the United States, perhaps more than in other countries, it has become increasingly evident that many forms of Mycobacteria which formerly were thought to be saprophytic are being found in diseased human tissues. In addition, these tissues demonstrate invasion and pathogenic proclivities for man as well as for certain laboratory animals, especially in the mouse and the hamster. Careful study of increasing numbers of patients with disease caused by these atypical Mycobacteria has demonstrated a picture clinically and pathologically very similar to tuberculosis. However, since the organisms do not produce typical pathological changes of tuberculosis in the guinea pig they have been classified erroneously as saprophytes.

Infection with one of the several species of atypical Mycobacteria may result in hypersensitivity of a low order of magnitude to tuberculin, prepared from the human variety of tubercle bacillus. Specific tuberculins prepared from certain atypical strains, notably the photochromogens and the nonphotochromogens, or "Battey" strains, may incite a much larger reaction in such patients, suggesting that many weakly positive reactions to standard tuberculin may represent cross reactions rather than "nonspecific" reactions.

Sources of methods of dissemination of infection with atypical Mycobacteria are at present poorly understood, but geographic areas of prevalence are known to exist.

In Texas, an increasing number of patients are being recognized with predominantly pulmonary and lymph node disease. From these, photochromogenic organisms have been isolated. Since the photochromogens may demonstrate considerable resistance to commonly used antituberculosis drugs, recognition by the laboratory worker and accurate reporting to the physician is important. Far advanced destructive lung disease and death have been observed as a result of infection with photochromogens, so that these organisms no longer should be reported or considered as saprophytes.

—Committee on Tuberculosis,
Texas Medical Association.

Prescription Drug Industry Growth Cited by Economist

The prescription drug industry is providing new jobs three times faster than all other manufacturing, while growing in dollar volume twice as fast as the national economy, Dr. Jules Backman, economics research professor of New York University, says.

Addressing the Pharmaceutical Manufacturers Association at its annual meeting, Dr. Backman pointed out that the industry's wholesale prices have declined 6 per cent during the period since 1947-1949, while the all-commodities index has risen 18.9 per cent.

Nonprofit Hypnosis Foundation Chartered in Illinois

Seminars on Hypnosis Foundation, a nonprofit teaching and research institute in hypnosis, has been chartered in Illinois to further the scientific development of hypnosis.

The organization will facilitate cooperation among scientists using hypnosis, make scientific use of hypnosis more effective in promoting human welfare, and increase public understanding of the subject. Funds will be used to promote research projects in hypnosis, offer grants-in-aid to institutions of higher education, provide fellowships in teaching institutions, and recognize significant accomplishment in the field with awards.

Dr. Milton H. Erickson, Phoenix psychiatrist, is chairman of the board of governors. Chairman of the board of trustees is Frank A. Pattie, Ph.D., professor of psychology, University of Kentucky.

Founding members are Dr. E. E. Aston, West New York, N. J., dentist and vice-president of the American Society of Clinical Hypnosis; Dr. Seymour Hershman, Chicago physician and secretary of the American Society of Clinical Hypnosis; Dr. Irving I. Secter, Chicago dentist and president of the Chicago Society of Clinical Hypnosis; and Dr. Erickson.

Fellowship is limited to any qualified physician, dentist, or psychologist (with a degree of Ph.D. or its equivalent) who has completed a satisfactory training program in hypnosis. The foundation will sponsor seminars and advanced teaching programs throughout the country.

Office address of the organization is 6770 N. Lincoln Avenue, Chicago.

Polio Vaccine Surplus Now May Omen Summer Cases, Burney Warns

Supplies of unused polio vaccine have reached a high of 26,400,000 doses although more than 90,000,000 Americans still need to be vaccinated, Dr. Leroy E. Burney, surgeon general of the United States Public Health Service, has reported.

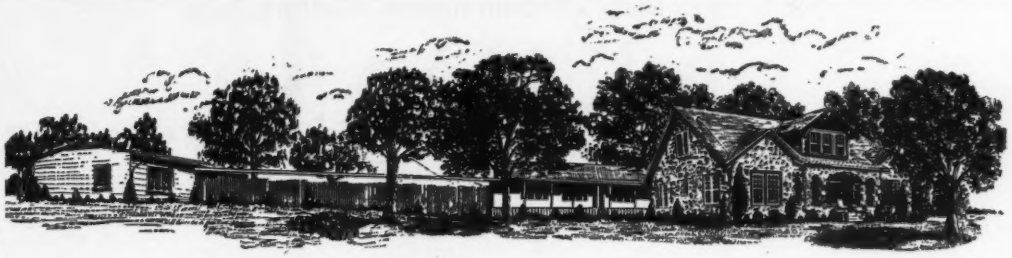
There has been a vaccine surplus every spring and winter for the past 4 years, Dr. Burney said, followed by a shortage in the summer—when the occurrence of polio cases reminds people they should get vaccinated.

The surgeon general urged the public to remember that vaccine is most effective if used before polio is prevalent, that vaccine manufacture takes about 4 months, that it is the third, and then the fourth, shot which gives greatest protection.

In the past 2 years, Dr. Burney said, infants and children under 5, living in neighborhoods where there are concentrations of unvaccinated people, have accounted for almost half of the paralytic cases.

Rehabilitation Journal Recorded for Blind

Rehabilitation Literature, an interdisciplinary journal published by the National Society for Crippled Children and Adults for professional personnel and students in physical rehabilitation, will be reproduced on request as a recording for blind persons who work and study in the same field. The 1960 issues (12) of the magazine are scheduled for reproduction by Recordings for the Blind, Inc., 121 East 58th Street, New York 22. This will be the first time the organization has undertaken to record a periodical.



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1. Innerfield, I.: Clinical report cited with permission
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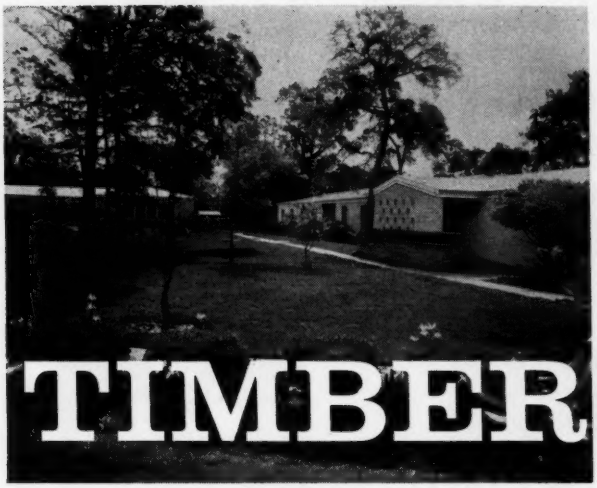

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GERALDINE SKINNER, B.S., O.T.R., Director of Occupational Therapy
LOIS TIMMINS, PH.D., Director of Recreational Therapy
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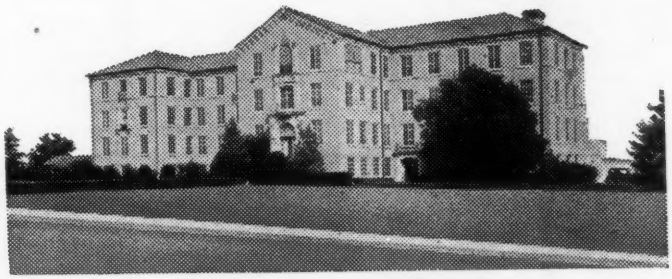

WICHITA FALLS CLINIC-HOSPITAL

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James T. Lee, M.D.
Charles H. Wilson, M.D., F.A.C.S.

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Warren T. Kable, M.D.
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ADMINISTRATIVE OFFICER
Bertha McNeill, Administrator

Film Selections Available

Texas Medical Association members are invited to utilize the film selections available in the Memorial Library, Austin.

Members of the staff report that the tape library is being expanded constantly. Audio-Digest medical lectures are recorded by outstanding physicians and scientists. Included in each tape is an edited formal paper or panel discussion. Older subscriptions have been reviewed this year and two new fields have been added, which allow requests on the following subjects to be answered: internal medicine, surgery, pediatrics, anesthesiology, and general practice.

All tapes are for standard tape recorders and play at 3 3/4 speed. A listing of all tape holdings will be sent upon request.

Gifts to the Library

Dr. Charles M. Darnall, Austin, 210 books.
Dr. Morris Davidson, Austin, 8 journals, 15 bulletins.
Dr. J. E. Johnson, Austin, 1 journal, 3 reprints.
Dr. R. A. Neely, Bellville, 10 bound journals, 9 journals.
Dr. Troy Shafer, Harlingen, 136 journals.

★ Books

Books Newly Acquired

Academy of Religion and Mental Health: *Religion, Science and Mental Health,* New York, New York University Press, Josiah Macy, Jr., Foundation, 1959.

Ambrose, Gordon, and Newbald, George: *Handbook of Medical Hypnosis,* ed. 2, London, Bailliere, Tindale and Cox, 1958.

Bakwin, Harry, and Bakwin, Ruth: *Clinical Management of Behavior Disorders in Children,* ed. 2, Philadelphia, W. B. Saunders, 1960.

Bonstein, Isidore: *Psychoprophylactic Preparation for Painless Childbirth,* New York, Grune and Stratton, 1960.

Bowers, Warner F.: *Surgical Gastroenterology,* Springfield, Ill., Charles C Thomas, 1960.

Britannica: *Book of the Year, 1960,* Chicago, Encyclopaedia Britannica.

Brooks, Stewart M.: *Basic Facts of Body Water and Ions,* New York, Springer, 1960.

Bruner, H. D., Editor: *Methods in Medical Research,* Vol. 8, Chicago, Year Book Publishers, 1960.

Ciba Foundation Symposium: *Biochemistry of Human Genetics,* Boston, Little, Brown and Co., 1959.

Ciba Foundation Study Group: *Cancer of the Cervix,* Boston, Little, Brown and Co., 1959.

Ciba Foundation: *Colloquia on Ageing . . . Lifespan of Animals,* Boston, Little, Brown and Co., 1959.

Ciba Foundation: *Significant Trends in Medical Research,* Boston, Little, Brown and Co., 1959.

Ciba Foundation Study Group: *Virus Virulence and Pathogenicity,* Boston, Little, Brown and Co., 1960.

Cole, Warren H., and Puestow, Charles B.: *First Aid Diagnosis and Management,* ed. 5, New York, Appleton-Century-Crofts, 1960.

Davis, Loyal: *Fellowship of Surgeons—A History of the American College of Surgeons,* Springfield, Charles C Thomas, 1960.

Gallagher, J. Roswell: *Medical Care of the Adolescent,* New York, Appleton-Century-Crofts, 1960.

Gardner, Ernest; Gray, Donald J.; and O'Rahilly, Ronan: *Anatomy,* Philadelphia, W. B. Saunders, 1960.

Glasser, Otto: *Dr. W. C. Röntgen,* ed. 2, Springfield, Ill., Charles C Thomas, 1958.

Gorbadei, N. K.: *Intraarterial Infusion of Procaine in Therapeutic Paracice,* New York, Consultants Bureau, 1960.

Goshen, Charles E.: *Psychiatric Architecture,* Washington, American Psychiatric Association, 1959.

Greenberg, David M., and Harper, Harold A.: *Enzymes in Health and Disease,* Springfield, Ill., Charles C Thomas, 1960.

Hilliard, Marion: *Women and Fatigue,* Garden City, Doubleday, 1960.

Hunter, George W.; Frye, William W.; and Swartzwelder, J. C.: *A Manual of Tropical Medicine,* ed. 3, Philadelphia, W. B. Saunders, 1960.

Kitay, Julian I., and Altschule, Mark D.: *Pineal Gland,* Cambridge, Commonwealth Fund, 1954.

Marti-Ibanez, Felix: *Henry E. Sigerist on the History of Medicine,* New York, MD Publications, 1960.

Marvin, H. M.: *Your Heart, A Handbook for Laymen,* Garden City, Doubleday, 1960.

Mautner, H. Eric: *Doctor in Bolivia,* Philadelphia, Chilton Co., 1960.

Book Notes

Albert Schweitzer—The Story of His Life

JEAN PIERHAL. 160 pages. $3. New York, Philosophical Library, 1957.

Not a formal biography, Jean Pierhal's book is a profile on the genius of a man who has been called "the greatest human being in the world."

The interest to doctors specifically is, of course, the fact that Albert Schweitzer obtained a medical degree for the sole purpose of embarking on a career as medical missionary in Africa. At the time he made the decision to study medicine for missionary purposes, he voluntarily renounced a comfortable life and outstanding recognition as a theologian and as a musician with an honored position as a university professor in Strasbourg. All this he and his bride gave up for a life of hardship, danger, and sacrifice, because Albert Schweitzer's principles demanded that he express his Christianity in deeds of service bestowed upon humble human beings, rather than in words of lengthy dissertations.

The chapter describing his arrival at this conclusion (chapter 6, "The Great Decision") plus the later chapters describing establishment of the now famous hospital at Lamferene in equatorial Africa are probably the most interesting in the book for a medical reader.

Although the subject of the book is a very fascinating human being, the style of the writing itself has a rather marked unevenness. Perhaps this is due to whatever is

lost in translation. Also, characters are not portrayed in any sort of depth, such as would be found in a definitive biography. There are numerous illustrations, but most of them are of rather mediocre quality and interest. However, the book does afford, at least, an introductory acquaintanceship with a wonderful human being.

—Morris Polsky, M.D., Austin.

A Modern Practice of Obstetrics

D. M. STERN, M.B., B.Ch. (Cantab.), F.R.C.S., F.R.C.O.G., Obstetric and Gynaecological Surgeon, West Middlesex Hospital and its annexes; Lecturer in Obstetrics, West London Hospital Medical School; Examiner to the University of London, the Examining Board in England, and the Central Midwives Board; and C. W. F. BURNETT, M.D. (Lond.), F.R.C.S., F.R.C.O.G., Obstetric and Gynaecological Surgeon, West Middlesex Hospital and its annexes; Assistant Lecturer in Obstetrics, West London Hospital Medical School; Examiner to the Central Midwives Board and the General Nursing Council. 248 pages. $7. London, Bailliere, Tindall and Cox, 1952.

As stated in the preface: "This book sets out the practice of obstetrics at the West Middlesex Hospital, and is the result of experience gained from some 50,000 consecutive deliveries."

The text omits pure anatomy and physiology. It was the purpose of the authors to write a new textbook based upon their experience, rather than upon the common rehash statements which follow from one textbook to another without substantiation. The style of writing is easily readable and the book is printed in the "easy on the eye" two column method. There are many excellent line drawings present.

Normal and abnormal obstetrics are covered completely, whereas operative procedures suitable for the obstetrician are not thoroughly nor adequately presented.

Of interest in the appendix are case records suitable for the average hospital. Some of the obstetrical practices do not conform to those which are observed in the United States. However, the basic principles of obstetrics which are presented are sound and acceptable wherever obstetrics is practiced.

I cannot recommend this book for a man limiting his practice to obstetrics; however, it might be useful for one's library collection.

—Milton Turner, M.D., Austin.

Clinical Proctology

J. PEERMAN NESSELROD, M.Sc. (Med.), F.A.C.S., Assistant Professor of Surgery, Northwestern University Medical School; Attending Surgeon, Division of Proctology, Evanston Hospital, Evanston, Ill. ed. 2. 296 pages. $7. Philadelphia and London, W. B. Saunders Company, 1957.

An excellent book for the general practitioner, Dr. Nesselrod's volume also contains a great many items which will be of interest to the specialist. The section on anatomy and anal infection is of particular interest.

Although the explanation of the etiology of hemorrhoids, on the basis of infection would not necessarily be accepted universally, it is at least another explanation. In general, the techniques are acceptable and conventional. The explanation of the formation of abscesses and fistulas is excellent as well as the chapters on postoperative care.

Chapters dealing with prolapse and anorectal malformations are incomplete and perhaps should have been left to a wider concept including the abdominal approach. Likewise, the chapters on neoplastic disease are lacking in completeness because of the absence of and correlation with the abdominal procedures involved in the treatment of these conditions.

—Robert J. Rowe, M.D., Dallas.

★ American Medical Association

AMA Meets June 13-17 In Miami Beach

Miami Beach will be the site June 13-17 of the 109th annual meeting of the American Medical Association, at which nearly 2,000 physicians will participate in presenting the scientific program.

Two general scientific meetings will be held in the Grand Ballroom of the Fontainebleau Hotel, and other lectures, symposiums, and panel discussions will be held in the Fontainebleau, Eden Roc Hotel, and in the new Miami Beach Exhibition Hall. Headquarters for the sessions on dermatology, which are being held jointly with the Society for Investigative Dermatology, will be at the di Lido Hotel.

The opening general scientific meeting is scheduled for Monday afternoon, June 13, with Dr. Carl A. Lincke, chairman of the American Medical Association Council on Scientific Assembly, presiding. Following the Joseph Goldberger Lecture on Clinical Nutrition at this session, the symposium on nutrition will be conducted. Included in the symposium is an address by Dr. Grace A. Goldsmith, professor of medicine at Tulane University School of Medicine, New Orleans.

Contributing to the second general meeting on Tuesday morning, June 14, are the sections on anesthesiology, diseases of the chest, general practice, internal medicine, pediatrics, pathology and physiology, and surgery. Title of this symposium is "Evaluation and Preparation of Patients for Anesthesia and Surgery."

In addition to the two general scientific meetings, section programs will contribute to the diversified scientific scope of the annual meeting. The section on surgery will feature a symposium and panel discussion, developed from suggestions obtained from a survey of the heads of departments of surgery in the nation's medical schools.

Meeting throughout the week will be the House of Delegates, including eight representatives from Texas. The House will name a recipient of the Distinguished Service Award and will announce the winner of the Goldberger Award for outstanding contributions in the field of nutrition.

Assuming office as president of the AMA will be Dr. E. Vincent Askey, Los Angeles, who will be formally inaugurated on Tuesday, June 14. To be named during the meeting will be a president-elect.

On display in the Miami Beach Exhibition Hall will be about 290 exhibits. Of interest will be a new special exhibit on body fluid disturbances which will offer a complete course on body fluids. Another noteworthy exhibit is a special one on fractures, including booths on fractures of the ankle, hip, wrist, tibia and fibula, children's fractures, and fractures resulting from falls on the outstretched hand. Motions picture and television programs will be coordinated with the scientific program in the exhibition hall.

The National Civil Defense Conference will be held at Miami Beach on Saturday, June 11, immediately prior to the opening of the annual AMA meeting. Sponsored by the AMA Council on National Security, the conference will be presented by the Medical Department of the United

States Navy under the direction of Rear Admiral Calvin B. Calloway, MC, USN, assistant chief of the bureau of medicine and surgery for research and military medical specialties. AMA President-Elect Dr. Askey will address the opening session. A conference highlight will be the erection of components of a 60-bed field hospital by the Second Marine Division. To be demonstrated are modern techniques of teaching first aid and self aid in the event of disaster.

★ Texas Medical Association

TMA's First Lady President Sparks 1960 Annual Session

A superior scientific program and a marathon business session, plus the installation of its first woman President, marked the ninety-third annual session of the Texas Medical Association held in Fort Worth April 9-12.

A total of 3,021 persons registered for the Saturday-Tuesday meeting, Texas doctors accounting for 1,796 of these and the Woman's Auxiliary for 630.

Twenty-six guest speakers and 26 special speakers headlined the scientific program. Crowded into the busy 4-day period were specialty group meetings, refresher courses, scientific section programs, general meetings, technical exhibits, scientific exhibits, motion picture films; business, and social events.

Signs of the times were, of course, a physicians' golf tourney, the sophisticated music of Les Elgart's band at the President's Party, and the number of doctors coming and going by private plane.

A Lady Becomes "The Doctors' Doctor"

For the first time in the 107 year history of the Texas Medical Association, a woman, Dr. May Owen of Fort Worth, became President.

In her presidential address, Dr. Owen stressed the importance of strengthening the position of county medical societies, of a strong scientific program for all Texas doctors, and of Association participation in a planned program of medical care for the state's aged indigent. She urged county medical societies to guarantee and publicize the availability of medical care for all, regardless of ability to pay; to revitalize their grievance committees; to evaluate their emergency call services; and to establish joint conference committees at all Texas hospitals. Of major importance also, she pointed out, is that doctors make a concerted effort to improve relations with the press and that they dedicate themselves to elimination of any abuses of voluntary prepaid medical or hospital insurance.

Dr. Harvey Renger of Hallettsville became President-Elect of the Texas Medical Association during the Fort Worth annual session.

A second woman President taking office at the Fort Worth annual session was Mrs. Ramsay Moore of Dallas, who was installed as the forty-third President of the Woman's Auxiliary.

Dr. Harvey Renger, Hallettsville, was named President-Elect of the Texas Medical Association. Mrs. William C. Barksdale, Borger, was named to that position by the Auxiliary.

Other officers elected were Dr. R. L. Deter, El Paso, Vice-President; Dr. C. P. Hardwicke, Austin, and Dr. James D. Murphy, Fort Worth, again Speaker and Vice-Speaker of the House of Delegates respectively.

Dr. Elliott Mendenhall, Dallas, was elected Trustee to succeed Dr. G. V. Brindley, Temple.

Four reelected Councilors included Dr. Henrie E. Mast, Midland, Second District; Dr. David Wade, Austin, Seventh District; Dr. Carlos E. Fuste, Jr., Alvin, Eighth District; and Dr. Herbert H. Duke, Baytown, Ninth District. Elected Councilor of the Tenth District was Dr. Gail Medford, Lufkin.

The four American Medical Association delegates whose terms expired were reelected. They were Dr. Troy A. Shafer, Harlingen; Dr. John K. Glen, Houston; Dr. G. W. Cleveland, Austin; and Dr. James H. Wooten, Columbus.

Also reelected were the four alternate delegates with expiring terms. These included Dr. John L. Otto, Galveston; Dr. Robert W. Kimbro, Cleburne; Dr. Ridings E. Lee, Dallas; and Dr. E. P. Hall, Jr., Fort Worth.

TMA House of Delegates Votes Against Citizenship for Members; To Increase Trustees to Seven

The Texas Medical Association House of Delegates, in one of the lengthiest, busiest sessions in years, voted against making United States citizenship a requirement for Association membership, reiterated its opposition to government control of medicine, and initiated action to increase the size of the Board of Trustees to seven.

In cooperation with county medical societies, the Association this year will conduct a survey to obtain data on community activity of physicians, including their contributions to medical care of the elderly.

The Board of Trustees authorized funds, and the House voted, for a 1961 school health conference, probably to be held in Houston. The move was made as a result of enthusiastic reports on a similar recently completed conference sponsored by the Association, the Dallas County Medical Society, and the Dallas Independent School District.

Also receiving support from the House was anticipated enabling legislation to put into effect vendors medical care payments as voted by the Texas electorate.

New Insurance Plans Authorized

A business overhead insurance plan was authorized by the House of Delegates as the fourth insurance plan designed for members of the Texas Medical Association.

Good experience with the Association's disability insurance program permits the offering of greater coverage for those desiring it, plus a continuation of a 15 per cent bonus on claims under the plan. Reported to be operating satisfactorily was the Association life insurance plan, but experience with the accidental death and dismemberment insurance program has been such that, upon underwriters'

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(1) Miss Harriet Cunningham, Austin, late managing editor of the **Texas State Journal of Medicine,** registered pleasure over a bouquet of roses she received from the Council on Annual Session. Beside her sits executive Secretary C. Lincoln Williston, Austin. **(2)** Sharing a light moment is this presidential quartet including Dr. Milford O. Rouse, Dallas; American Medical Association President Louis M. Orr, Orlando, Fla.; Dr. May Owen, Fort Worth, President, Texas Medical Association; and Dr. Franklin W. Yeager, Corpus Christi, left to right. **(3)** The House of Delegates in action. **(4)** Busy spot before the House of Delegates meeting was the Credentials Committee table where delegates checked in. **(5)** A steady flow of arriving members surrounded the convention registration booth. Standing in background is new Woman's Auxiliary Executive Secretary Nola Acton. **(6)** Convention VIP's photographed together included eight past presidents. Standing, left to right, they are Drs. Milford O. Rouse, Howard O. Smith, J. Layton Cochran, George Turner; foreground, left to right, Drs. T. C. Terrell, Witten B. Russ, L. H. Reeves, and G. V. Brindley, Sr.

(1) Dr. J. H. Steger, Fort Worth, chairman of the Committee on General Arrangements, presents a bouquet from the Fort Worth Altrusa Club to Dr. May Owen at the President's Party. **(2)** Dr. Woodrow M. Avent, chairman of the Section on General Practice, discusses the program with guest speaker Dr. O. Theron Clagett, Rochester, Minn. **(3)** Talking medicine are two distinguished guest speakers, Dr. Joseph A. Hardy of St. Louis, and Dr. Eugene P. Pendergrass of Philadelphia. **(4)** Legislative matters were bound to come up in conversation between State Senator Crawford Martin of Hillsboro and Philip R. Overton, general counsel of the Texas Medical Association. **(5)** Fort Worth community leaders were honored at Tuesday's civic luncheon. **(6)** The Public Relations Committee's Dr. Joe Donaldson, Pampa, presents the third place Anson Jones Award to Mrs. Mary Tom Rasco, **Amarillo Globe-Times** reporter and executive secretary of the Potter-Randall Counties Medical Society.

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requests, the House approved increased premiums and decreased benefits for that program.

The House also voted support of a disability insurance program for American Medical Association members, since the proposed plan will not affect adversely the state plan already in effect.

Texas Elderly and Rural Indigent Needs Studied

Approval was given by the House of Delegates to various plans for bettering the care of Texas' elderly citizens, including efforts toward upgrading of nursing homes, increasing chronic illness beds in general hospitals, providing homemaker services, educating medical and nursing students in geriatrics, and establishing active county medical society committees on aging.

A special committee to serve under the Council on Medical Service and Insurance was authorized to study the problem of adequate hospital care for the rural medically indigent of the state.

The House voted to cooperate with the Farm Bureau in working out satisfactory answers to problems in health care in rural areas, and to work with various agencies and organizations interested in reducing the census of non-service-connected cases in Veterans Administration Hospitals.

Also adopted was a report urging the Texas State Health Department to plan, and put into operation, an effective program of tuberculosis control utilizing all feasible facilities available for the accomplishment of this objective.

House Takes Legislative Action

The House of Delegates gave its endorsement to establishment of the medical examiner system for all Texas counties.

It voted support of federal legislation for controlling the labeling of hazardous substances.

The House, after considerable debate, tabled a resolution opposing federal aid to medical schools.

As in previous years, the House opposed compulsory coverage of physicians under the federal social security system. Support was voted for permitting tax deferment on pension plans for the self-employed (Keogh bill) and for protection of states' rights.

The House of Delegates went on record as being unequivocally opposed to any type of national compulsory health insurance or Forand-type legislation.

House Votes By-Laws Revisions

Although the House of Delegates adopted extensive revision of chapters of the Association By-Laws which relate to county society membership and disciplinary procedure, most of the changes were in form and phraseology rather than in basic revision.

After some debate, the House turned down a resolution making United States citizenship a qualification for membership in the Texas Medical Association. County medical societies were reminded, however, that they have full authority over who shall or shall not become a member. The House pointed out that physicians who fail to take steps to become citizens of this country might be considered for suspension of license to practice.

Action to increase the Association Board of Trustees to seven members was initiated, but, since such a change involves an amendment to the Constitution, one year must pass before final action is taken.

On recommendation of the President, the House voted that a committee member who fails without good reason to attend two-thirds of the meetings of his committee during the year shall be automatically removed from it.

Last year the House of Delegates approved changes in the By-Laws to prohibit the Texas Medical Association from entering into contracts and from setting fee schedules. Two resolutions carried over from last year would have added these same prohibitions to the Constitution, but after considerable debate the House decided it would be unnecessary to incorporate into the Constitution these provisions now effective in the By-Laws.

Standing Committees Accepted

Made standing committees by the House of Delegates were the Committee on Rehabilitation, Committee on Spas, and Committee to Encourage and Assist Hospitals in Securing Accreditation.

Provision was voted to increase the membership of the Committee on Maternal Mortality to 15, and a Committee on Nutrition was approved. The House voted to continue the Committee on Reorganization as a special committee until its work is completed.

Appointment of a President's Advisory Committee will be left to the discretion of the President, the House disapproving inclusion of the three immediate past presidents as ex officio members.

Scientific Exhibits Take 12 Awards At Annual Session

Twelve awards went to 10 scientific exhibits which were judged most outstanding among 35 of their kind displayed at the Texas Medical Association's annual session in Fort Worth.

First place in the *individual exhibits* category and honorable mention in the *popularity poll* went to a display entitled "Renaissance in Otology" by Dr. W. P. Anthony, Fort Worth.

First place among *group exhibits* was awarded to "Bronchogenic Carcinoma" by Dr. Robert Shaw, Dr. Donald L. Paulson, and Dr. John L. Kee, Jr., all of Dallas.

First place for *institutional exhibits* was won by "Selective Visceral Arteriography" from the University of Texas Medical Branch, done by Dr. Robert N. Cooley, Dr. John R. Derrick, and Dr. Colvin H. Agnew, all of Galveston.

Popularity poll first place winner was "Treatment of Pulmonary Tuberculosis" by Dr. Ellison F. White and Dr. Carlos J. Quintanilla, Harlingen State Tuberculosis Hospital, and Dr. Lawrence M. Shefts, thoracic surgery consultant, San Antonio.

Two second place awards, one in *individual exhibits* and one in the *popularity poll*, went to "Surgery of the Hand," by Dr. J. Robert Cochran, Fort Worth.

"Positive Contrast Ventriculography" by Dr. McClure Wilson and Dr. S. R. Snodgrass, University of Texas Medical Branch, Galveston, won second place among *group exhibits*, while "Regional Perfusion of Cancer" from the University of Texas M. D. Anderson Hospital and Tumor Institute, Houston, won second place among *institutional exhibits*. The display was presented by Dr. John S. Stehlin, Jr., Dr. R. Lee Clark, and others.

Honorable mention awards were made for "Fate of Lead in Synovial Fluid" by Dr. Louis W. Breck, Dr. W. Compere Basom, Dr. Morton H. Leonard, Dr. Mario Palafox, and Dr. W. Kosicki of the El Paso Orthopedic Surgery Group, *individual exhibits* category; to "From Parenteral Digitalization to Oral Maintenance" by Dr. Robert B. Crouch, Houston, *group exhibits* category; and to an *in-*

stitutional exhibit of the United States Army Surgical Research Unit, Brooke Army Medical Center, Fort Sam Houston, by Col. Edward H. Vogel, Jr., MC; Lt. Col. Wilfred T. Tumbusch, MC; and Capt. Jerome J. DeCosse, MC, on "The Treatment of Burns of the Hands."

Indicative of the high caliber of scientific exhibits shown at annual session this year are those pictured here. Two awards went to "Renaissance in Otology" (top), as did two to "Surgery of the Hand" (bottom). Posing proudly with their popularity poll-winning exhibit (center) are Dr. Carlos J. Quintanilla, Harlingen, and Dr. Lawrence M. Shefts, San Antonio, at right.

Names Make the News At Fort Worth Session

"Names" made the news throughout the Fort Worth annual session, as individuals and groups were honored by the Texas Medical Association.

Dr. Pat Ireland Nixon of San Antonio and Dr. Willard Richardson Cooke of Galveston were elected to emeritus membership in the Association, one of the highest honors it can bestow.

General Practitioner of the Year title went to Dr. Elbert Dean Rice of Tyler.

Dr. G. V. Brindley, Sr., of Temple, retiring as a member of the Association Board of Trustees after 10 years, was honored for 50 years of service to the profession. Presented to him by the Board of Trustees during a session of the House of Delegates was a plaque bearing the words, "With deep appreciation of the distinguished and unselfish service to Texas Medicine—President, Trustee, Councilor."

Anson Jones Awards for outstanding lay medical reporting went to Blair Justice, *Fort Worth Star-Telegram*, first; Miss Marjorie Clapp of the *San Antonio Light*, second; *Miss Mary Tom Rasco* of the *Amarillo Globe-Times*, third; and John Whiting of the *Marshall News-Messenger*, special award for community service reporting.

Miss Harriet Cunningham, late managing editor of the *Texas State Journal of Medicine*, was presented a bouquet of roses by the Council on Annual Sessions in appreciation for her work on annual session arrangements in past years.

Dr. Rice: General Practitioner of Year

A commendation to Dr. Ralph E. Gray, former chairman of the Committee on National Emergency Medical Service, was contained in the report of that committee.

Thirty physicians were voted to honorary membership—among them the late Dr. Albert J. Schuett of Dallas, whose status was granted posthumously—and 30 others to inactive membership.

Dr. May Owen, President of the Texas Medical Association, was made an honorary life member of the Woman's Auxiliary in a surprise ceremony at an Auxiliary luncheon. She is the first physician ever to have been so honored by the group.

Harris County Medical Society introduced a resolution, adopted without referral to a reference committee, praising Dr. R. W. Kimbro, chairman of the Board of Trustees, for his excellent address to the society earlier in the year.

Past presidents of the Association were honored with the adoption of an official past presidents' lapel pin to be given to all living past presidents and to each president as he leaves that office.

Forty community leaders of Fort Worth and members of the Association's Fifty Year Club were honored guests for the general meeting luncheon, which was highlighted by an address by Dr. Louis Orr, President of the American Medical Association. His topic was "Pawns or Individuals?"

1932 TMA President John Hoskins Foster Cherishes Medical Honesty Most in Life

When an epidemic broke out in Laredo in 1902, there was considerable debate among local physicians as to whether the illness was malaria or yellow fever, and local opposition to quarantine was strong.

As a result, the state health officer began the search for a man who could go to Laredo with him and know how to examine blood for malarial parasites—in those days, no easy assignment.

The man he finally chose was a 26-year-old doctor who was an assistant physician at the Austin State Hospital and who had received his medical degree *cum laude* from the University of Texas Medical Branch only 2 years earlier. Though he had never seen an actual case of yellow fever, the young physician was able to eliminate malaria in the Laredo cases, spent a week among the sick, and then was packed off to (yellow fever mosquito-less) Mexico City to sit out a 10-day spell before returning home. The first night in Mexico, chills set in, and for several desperate days he fought the severe illness he had just diagnosed in others.

The young doctor was John Hoskins Foster, who became the sixty-sixth president of the Texas Medical Association 30 years later during an annual session held in Waco.

Born in Nelsonville, Austin County, on November 20, 1876, he was the son of Dr. G. W. Foster, a Confederate soldier who received his medical degree from the then University of Louisiana in 1869. The son's own medical career was interrupted twice by war: at the outbreak of the Spanish-American War, he dropped his studies temporarily to enlist in the Army and serve as a hospital steward in the First Texas Cavalry; during World War I he was a Navy lieutenant.

In 1904 Dr. Foster left his post at the Austin State Hospital to go to New York to study otolaryngology as a specialty. He returned to Texas to open a Houston office in 1906 and was married the following year to Miss Anne Vineyard of that city. They have one daughter, Mrs. G. E. Cranz of Fort Worth.

As all Texas Medical Association presidents do, Dr. Foster has led an extremely active professional life in addition to his practice. In 1913, he studied at the University of Vienna. In 1923 he was largely instrumental in organization of the Houston Eye, Ear, and Throat Hospital. In 1933, Southwestern University conferred an honorary doctor of science degree upon him. He has been president of the Harris County Medical Society, the South Texas District Medical Society, the Texas Ophthalmological and Otolaryngological Society, and several other groups. The American Laryngological Association elected him first vice-president, and the Texas Medical Association named him an honorary member in 1947.

Business has always intrigued Dr. Foster. In 1951, for example, he was named chairman of the board of the Houston First Federal Savings and Loan Association—29 years to the day since he was first elected to the board of directors.

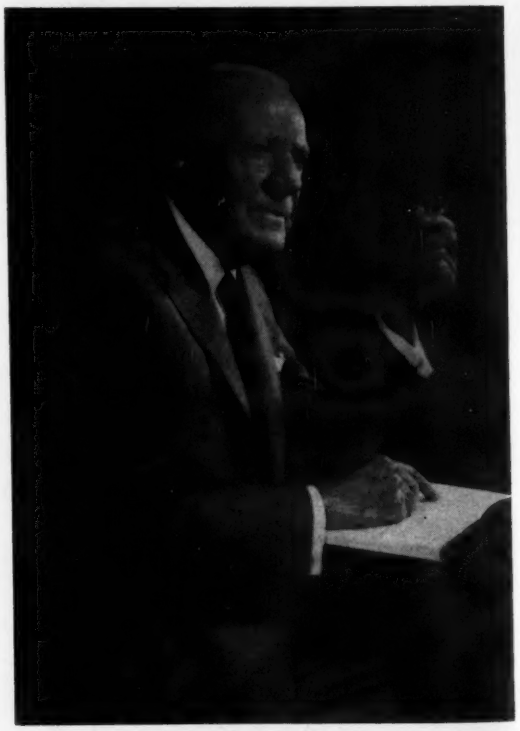
But he has been a sociable man, too, belonging to such "leisure time" institutions of our day as the Houston Club, the River Oaks Country Club, and the Houston Yacht Club. (His interest in at least one of these was precipitated by his favorite hobby, golf.) Dr. Foster is a Shriner and an Episcopalian.

As president of the Texas Medical Association, Dr. Foster emphasized activities he sees as the five areas important in the over-all purpose of organized medicine: scientific work, legislation, sociological activities, medical economics, and medical education. He stressed the need for close harmony among Texas physicians, the importance of careful selection of district councilors, a careful consideration of the principles of contract medicine. During his administration, reorganization of the Committee on Cancer was effected.

Now retired, Dr. Foster lives at Eagle Lake, where he devotes himself to his farm and ranch interests.

"I am not a prideful individual," he says, "but I think the one thing I cherish most in my life is that I always practiced medicine honestly."

This is John Hoskins Foster, president of the Texas Medical Association in 1932-1933: a study in leadership.



Dr. John H. Foster

★ County Societies

County Medical Society Briefs

The *La Salle-Frio-Dimmit Counties Medical Society* heard Dr. Donald Thayer Dodge, San Antonio psychiatrist, discuss "Depression Seen in General Practice," when it held its March 17 session in Dilley.

During the business portion of the meeting, Dr. John Crawford, Carrizo Springs, was appointed to fill the vice-presidency left vacant by the recent death of Dr. William S. Wilson, Jr. of that city. Dr. T. D. O'Connor and Dr. Emmett Wilson, both of Pearsall, and Dr. Clyde Myers of Cotulla were appointed to a cancer committee; and the society's meeting date was changed from the third to the first Tuesday of each March, June, September, and December.

The June meeting will be held in Pearsall with Dr. O'Connor as program chairman.

Members of the *Bexar County Medical Society* were guests of the commander and staff of the Aerospace Medical Center, Brooks Air Force Base, on April 5. The evening's program included a tour of the new teaching and research plant, with demonstrations of clinical and research activities. A cocktail-buffet preceded the program.

The *Tarrant County Medical Society* heard Lt. Col. Ernest Clark, chief of medical service at Carswell Air Force Base, discuss "Complications of the Flu and Staphylococcus Pneumonia" at its March 1 dinner meeting at the Carswell Officers' Club. Sixty-one members and 30 Carswell medical officers were present.

Dr. Robert E. Chapman, member of the medical jurisprudence committee, announced that Millard Heath, executive secretary of the Dallas County Medical Society, had been given a leave of absence to help with opposition to national Forand-type legislation.

Additional county medical society officers for the year are as follows:

Top o' Texas (Gray-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson).—President, Dr. Richard D. Falkenstein, Pampa; president-elect and vice-president, Dr. Woodrow W. Massad, Borger; secretary-treasurer, Dr. T. DeWitt Harvey, Pampa; delegate, Dr. Raymond M. Hampton, Pampa; alternate, Dr. W. G. Stephens, Borger; board of censors, Dr. Charles H. Ashby, Pampa; Dr. Stephens and Dr. William C. Barksdale, Borger.

Victoria-Calhoun-Goliad.—President, Dr. Richard C. Allen, Jr., Victoria; vice-president, Dr. F. M. Logsdon, Port Lavaca; secretary-treasurer, Dr. Ben H. White, Victoria; delegate, Dr. Joseph V. Hopkins, Victoria; alternate, Dr. Ern C. Mooney, Victoria; board of censors, Dr. Craig P. Bade, Dr. Thomas L. Sterne, and Dr. Winton L. Coleman, all of Victoria.

"Smoking and Lung Cancer" was the subject of Dr. Walter McCook, chest physician from Shreveport, who spoke before the *Harrison County Society* at its regular meeting, April 8, in Marshall. He told members that there is a definite, statistically significant, higher incidence of lung cancer in smokers than nonsmokers. Although it may be too much to expect inveterate smokers to stop the habit, he said, it is foolish for a nonsmoker to begin smoking in the light of newer knowledge of its harmful effects.

Dr. E. Stanley Crawford, assistant professor of surgery at Baylor University College of Medicine, Houston, discussed "Recent Advances in Cardiovascular Surgery" at a joint meeting April 12 of the *Nueces County Society* and the U. S. Naval Hospital, Corpus Christi. Medical officers at the base served as hosts for the group.

Captain L. G. Bell, new commanding officer of the hospital, was welcomed back to the city by many members.

Galveston County Society Honors Sixteen Physicians

Sixteen senior members of the Galveston County Medical Society were honored for their distinguished contributions to Texas Medicine at a formal banquet in Galveston April 20. Attending were their colleagues and students, Donald M. Anderson, assistant executive secretary of the Texas Medical Association, officials of the State Bar of Texas, the Chamber of Commerce, the Texas Pharmaceutical Association, and other special guests.

Chief speaker was Dr. May Owen of Fort Worth, President of the Texas Medical Association, who paid tribute to the honorees for their dedication to medicine in their 40 years or more of practice. Dr. John McGivney was master of ceremonies.

Those honored were Dr. Fred W. Aves, retired general practitioner now of Dickinson, who was unable to attend; Dr. Willard R. Cooke, retired chairman of the department of obstetrics and gynecology, University of Texas Medical Branch; Dr. G. W. N. Eggers, orthopedic surgeon, Galveston; Dr. William C. Fisher, retired general practitioner, Athens; Dr. Titus Harris, chairman of the department of psychiatry, University of Texas Medical Branch.

Members of the Galveston County Medical Society gathered for a formal banquet, April 20, in Galveston to honor sixteen senior members of the society for their contributions to Texas medicine.

Also Dr. J. L. Jinkins, Sr., obstetrician and gynecologist, Galveston; Dr. E. S. McLarty, Sr., general practitioner, president of the Galveston County Medical Society and the Texas Academy of General Practice; Dr. E. L. Porter, professor emeritus in physiology, University of Texas Medical Branch; and Dr. N. Prunansky, general practitioner, Galveston.

Also Dr. Edward Randall, general practitioner, Galveston; Dr. H. Reid Robinson, professor emeritus of obstetrics and gynecology, University of Texas Medical Branch; Dr. William B. Sharp, retired chairman of the department of bacteriology and preventive medicine which has since been dissolved at the University of Texas Medical Branch.

Also Dr. Will Spiller, Galveston dermatologist; Dr. C. T. Stone, Sr., retired chairman of the department of internal medicine, University of Texas Medical Branch; and Dr. Clarence Sykes, Galveston ophthalmologist.

Two hundred persons attended the party at the Buccaneer Hotel.

★ Woman's Auxiliary

"My Fair Lady" Holds Spotlight In Fort Worth Auxiliary Convention

Against a background of romance, song, and color from "My Fair Lady," the Woman's Auxiliary to the Texas Medical Association presented its annual convention, April 9-12, in Fort Worth. Its "fair lady" theme was a tribute to each individual member in her four-dimensional role as wife and homemaker in auxiliary and community service. The forty-second chapter of auxiliary history, "Cherish Our Heritage in Health," was concluded in a series of meetings and luncheons to fit the theme.

The executive board of the Auxiliary met April 9 at luncheon, called to order by Mrs. Haskell D. Hatfield, president. The keynote address was given by Mrs. O. M. Marchman, Sr., of Dallas. She identified "My Fair Lady" as the little lady, our official insignia, and with the ideals and heritage of the auxiliary. Greetings from Texas Medical Association were given by Dr. H. O. Padgett of Marshall, chairman of the Advisory Committee. "After eighteen years of receiving advice from a member of the auxiliary," Dr.

Mrs. Haskell D. Hatfield gives Woman's Auxiliary address before the Texas Medical Association's House of Delegates.

Padgett said, "it is a pleasure to be asked to give advice to the auxiliary." Recommendations and reports were presented by officers and chairmen.

On Sunday afternoon, a conference of Councilors and Council Women was conducted by Mrs. G. Bedford Brown of Angleton, first vice-president. Her theme, "How We Operate," was punctuated by organizational plans and procedures. Dr. Travis Smith of Abilene, vice-chairman of the Board of Councilors, spoke on the opportunities and responsibilities of council women, making recommendations toward more effective program and organization in districts.

Memorial services of the Texas Medical Association and Woman's Auxiliary were held on Sunday, April 10, at 5 p.m. Memorial addresses were given by Dr. Milford O. Rouse of Dallas and Mrs. John King Glen of Houston.

Mrs. H. S. Renshaw of Fort Worth was chairman for the Auxiliary Past Presidents' Dinner Sunday evening at Shady Oaks Country Club. Mrs. A. B. Pumphrey, Fort Worth, showed pictures of her world tour.

The general assembly was called to order Monday morning. The Reverend John Leatherbury of All Saints' Episcopal Church gave the invocation, followed by the National Anthem led by Mrs. Frank Halpin of Fort Worth. Mrs. George Turner of El Paso, national historian, brought greetings from the Woman's Auxiliary to the American Medical Association and Mrs. Oscar W. Robinson of Paris, Southern parliamentarian, brought greetings from the Woman's Auxiliary to the Southern Medical Association.

Mrs. Scott Haggard, Denton, and Mrs. Richard Hudson, Corpus Christi, accepted some of the Auxiliary awards.

Among actions taken by the convention were the following: Mrs. E. H. Cary and Mrs. O. M. Marchman of Dallas, first president and secretary of the auxiliary, were made honorary life presidents of the Woman's Auxiliary to the Texas Medical Association; $1,000 was given to AMEF as a memorial to auxiliary members deceased during the past year; proposed revisions were tabled for further study, excepting those concerned with finance; year's contributions were made to the Library Fund to be used to purchase new films; Dr. May Owen of Fort Worth, president-elect of Texas Medical Association, was made an honorary life member of the Auxiliary.

County presidents reported on highlights of their year's work.

Monday Luncheon

At luncheon the Medi-Larks, Tarrant County Auxiliary's choral group, dressed in gay flower girl costumes, sang a medley of songs from "My Fair Lady," directed by Mrs. Halpin and accompanied by Dr. Feliks Gwozdz. Presiding, Mrs. Hatfield said, "The fair ladies of auxiliary are you. Our 1960 production unfolds against this lovely background of romance. Among the *dramatis personae* are our leading ladies, whom we honor today: our county presidents; each of them took our script, adapted it to a local stage and setting, and produced a successful drama. A special heroine who became the ideal wife, setting us an example in devotion, as she accompanied her husband and encouraged him in his work as president of Texas Medical Association, is Mrs. Franklin W. Yeager."

"In the supporting cast are many who assist us, working as stagehands sometimes, seldom seen or heard, members of the staff at the central office. Among these who have helped us through the years, known by some of us as 'Miss Auxiliary,' beloved by all, Miss Harriet Cunningham, editor of the *Journal*."

"And now, the star of our story, Dr. May Owen." Handing Dr. Owen a card of parchment embossed in gold, Mrs. Hatfield said, "Dr. Owen, by authority of this convention I present you this Honorary Life Membership in the Auxiliary. We pledge you our love and loyalty."

The luncheon was concluded with an address by Dr. Granville T. Walker, University Christian Church, Fort Worth, "Pygmalion in Eternity," which illuminated the theme with spiritual meaning, from the original Greek myth to a modern "fair lady" who comes to full life through faith.

Tuesday Business

Tuesday's general session was a continuance of reports from county presidents and council women. Mrs. Milton J. Loring of Midland, historian, presented awards. The Gonzales Auxiliary, represented by Mrs. James C. Price, received the silver loving cup for increase in membership.

"My Fair Lady" is the doctor's wife, according to Dr. Joe R. Donaldson, Pampa, chairman of the Committee on Public Relations and Public Service of Texas Medical Association. Said Dr. Donaldson: "What should the doctor do if his public relations is not so good? Get a partner interested in good PR. Get a partner with a good scientific background. Get one interested in P.-T.A., church, and so forth; one good at handling finances; one interested in taking care of children. Where will he find such a partner? The doctor's wife, 'My Fair Lady,' the best public relations partner the doctor has."

Mrs. John D. Gleckler, Denison, chairman of the Nominating Committee, presented the following slate of officers for 1960-1961, who were elected unanimously:

President-elect, Mrs. William C. Barksdale, Borger; first vice-president, Mrs. Richard L. Hudson, Corpus Christi; western vice-president, Mrs. Joe R. Donaldson, Pampa; eastern vice-president, Mrs. J. Griffin Heard, Houston; northern vice-president, Mrs. Walter McCall, Ennis; southern vice-president, Mrs. R. E. Leslie, El Campo; recording secretary, Mrs. M. Lake Fowler, Jr., Galveston; corresponding secretary, Mrs. Charles Warren, Dallas; treasurer, Mrs. Garland G. Zedler, Austin; and parliamentarian, Mrs. William Hibbitts, Texarkana. Mrs. Ramsay H. Moore of Dallas took over as president.

Mrs. Forrest C. Orman, Lufkin; Dr. Travis Smith, Abilene; Mrs. G. Bedford Brown, Angleton; and Dr. H. O. Padgett, Marshall, visit at the Conference of Councilors and Council Women.

A musical style show and luncheon honoring Mrs. Hatfield, retiring president, and Mrs. Moore, incoming president, at the River Crest Country Club was an enjoyable and unique affair. "Had There Been An Act III of 'My Fair Lady'" (with apologies to Moss Hart) was the setting for fashions of Meacham's.

Dr. Felix Gwozdz and Mrs. Burl V. Thompson, both of Fort Worth, helped provide entertainment.

Mrs. Renshaw installed the new officers with a ceremony of romance "when knights were bold, ladies fair, and installations were called 'investures.'" To each officer, she presented a miniature crown, tiara, or royal plume.

Post-Convention Meeting

The post-convention Board meeting was held Tuesday afternoon with Mrs. Moore presiding. After greetings, introduction, and program discussions, the meeting was adjourned.

"Alertness and Action for Achievement" will be the Auxiliary theme for 1960-1961.

At the President's Party Tuesday night, the fair ladies and their escorts dined, were entertained, and danced to the music of Les Elgart and his orchestra.

Among special guests of the convention were Mesdames Grace Martin, College Station; Joseph A. Hardy, St. Louis; Peter C. Kronfeld, Wilmette, Ill.; Don H. O'Donoghue, Oklahoma City; Edward O. Harper, Cleveland, Ohio; J. T. Willis, President of the Woman's Auxiliary to the Louisiana State Medical Society; E. T. Townson, Shreveport; and C. Lincoln Williston, Philip R. Overton, and Jon Hornaday, all of Austin.

—MRS. HAL V. NORGAARD, Denton.

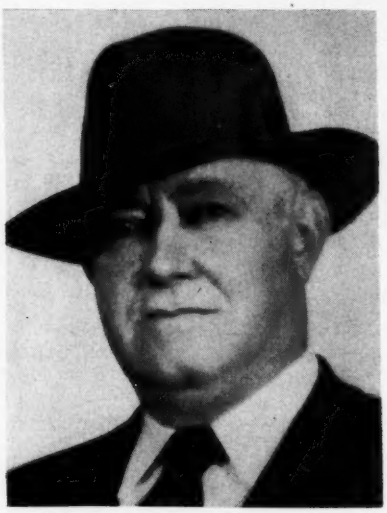
RECENT DEATHS

DR. ELMER C. SCHOFIELD

Dr. Elmer Clark Schofield, Orange, died March 3, 1960.

A native of Ypsilanti, Mich., Dr. Schofield was born May 4, 1899, the son of Arthur M. and Hattie (Clark) Schofield. Dr. Schofield attended high school in Amherst, Ohio, and was graduated in 1926 from Ohio University at Athens. He received his medical degree from the University of Louisville School of Medicine in Kentucky in 1930.

A general practitioner, he served his internship with the United States Army in San Antonio and completed his residency at St. Joseph's Hospital in Louisville, Ky., and at Cumberland General Hospital in New York in 1933.



DR. ELMER C. SCHOFIELD

Before establishing his practice in Orange where he was chief of staff at Orange City Hospital, Dr. Schofield practiced at Fleming, Ky., and at Schulenburg.

From 1917 to 1919, Dr. Schofield had served as a private with the United States Army in France. Later, in 1930 and 1931, he held the rank of captain, while serving his internship in San Antonio.

Dr. Schofield was a member of the American Medical Association, the Texas Medical Association, and the Orange County Medical Society. He was a thirty-second degree Mason. His church affiliation was Episcopal.

Survivors are his wife, the former Miss Bess Paddleford of Mason, whom he married June 18, 1952, in Orange, and a son, Jimmy Schofield of Washington, D. C.

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

DR. JOHN E. SPARKS

DR. JOHN E. SPARKS

Dr. John E. Sparks died March 9, 1960, at his home in San Antonio of a coronary occlusion.

A native of Valley Mills, where he was born on a nearby ranch on September 1, 1877, Dr. Sparks received his early education in the Bosque County town. He was awarded his premedical and medical degrees, respectively, from the University of Tennessee and the University of Tennessee College of Medicine, Memphis.

Following his graduation in 1910, he began practice in Rockport, moving from there to Floresville, where he remained until 1929. From Floresville he moved to San Antonio, where he practiced until his retirement.

At the age of 78, Dr. Sparks published his autobiography, "An M.D. the Hard Way," which he said he wrote primarily for his children so that they might know more about his younger days.

He was a member of the American Medical Association, the Texas Medical Association to which he was elected an inactive member in 1958, and the Bexar County Medical Society. He previously had served as secretary and as president of Karnes-Wilson Counties Medical Society.

Survivors include two daughters, Mrs. William Bowling and Mrs. Lola Mitchell, both of San Antonio, and a son, August Sparks, Corpus Christi. His wife died in 1952 and a son, Virgil D. Sparks, died this year.

DR. JOSEPH W. BOURLAND, SR.

Dr. Joseph W. Bourland, Sr., Dallas, professor emeritus of obstetrics and gynecology at the University of Texas Southwestern Medical School, died February 20, 1960, of a cerebral hemorrhage at the home of a son.

Credited with the invention of the incubator for premature infants nearly 50 years ago, Dr. Bourland was a practicing physician for almost 60 years before his retirement in 1955. He had begun his practice in 1897 in Dallas following the completion of his residency at New York Infant Asylum, New York. He had attended Baylor University, Waco, and Columbia College of Physicians and Surgeons, New York; and had completed his internship at

Elizabeth General Hospital and Dispensary, Elizabeth, N. J.

For 10 years, Dr. Bourland was chief of obstetrical service at Florence Nightingale Maternity Hospital, a unit of Baylor University Hospital, at Dallas; and during World War I he served as a captain in the Medical Corps of the United States Army. One of the founders and a director of the Dallas Medical and Surgical Clinic, Dr. Bourland had been one of the first Dallas physicians to specialize in the new field of obstetrics and gynecology in 1915. He also served 10 years as a member of the board of governors of Parkland Hospital, Dallas.

In 1935, he served as president of the Texas Association of Obstetricians and Gynecologists. In addition, he was a member of the American Board of Obstetrics and Gynecology. He belonged to the American Medical Association, the Southern Medical Association, the Texas Medical Association of which he was named an honorary member in 1955, and the Fourteenth District Medical Society.

For 20 years, Dr. Bourland was a member of the board of stewards of Dallas' First Methodist Church. His father, the late Dr. Hillen Armour Bourland, had been pastor of the church. His mother was the former Pricilla Howland. Born on October 21, 1872, in Hanibal, Mo., Dr. Bourland later married the former Miss Virgie Bookhout, who died in 1944.

In addition to his medical and church duties, Dr. Bourland was a charter member of the Dallas Athletic Club. In recent years he had turned to oil painting as a hobby.

Surviving him are two sons, Dr. J. Wilbur Bourland, Jr., and Dr. John B. Bourland, and a daughter, Mrs. Frank Kendrick, all of Dallas.

DR. C. S. CARTER

Dr. Charles S. Carter, Bells, died December 9, 1959, in Sherman of emphysema.

Born north of Bells on November 1, 1878, Dr. Carter was the son of J. W. and Sarah Ann Carter. He was educated in Bonham and was graduated from the Georgia College of Eclectic Medicine and Surgery at Atlanta in 1901. He also attended the American Medical College, St. Louis, and Tulane Polyclinic, New Orleans.

Dr. Carter practiced in Savoy from 1908 until 1923, in Whitewright from 1923 until 1926, and in Bells from 1926 until 1959.

In 1956, residents of Bells feted the pioneer physician with "Dr. Carter Day," at which time he reported he had delivered more than 3,000 babies, and all but 6 had been delivered in homes of the mother.

A member of the American Medical Association and the Texas Medical Association for many years, Dr. Carter had belonged to the Grayson County Medical Society. For 15 years he had served on the Texas State Board of Medical Examiners, and he had been president of the Texas Eclectic Medical Association. He also was a Mason.

Dr. Carter married Miss Maude Frances Short of Savoy in 1904. She died in June, 1931. He exchanged wedding vows with Mrs. Ethel Belote in Greenville in 1939.

Surviving besides Mrs. Carter of Bells are two daughters, Mrs. M. D. Johnson of Dallas and Mrs. M. W. May of Austin, and a son, Charles W. Carter of Dallas. Also surviving is a sister, Mrs. Nora Burks of Pauls Valley, Okla.

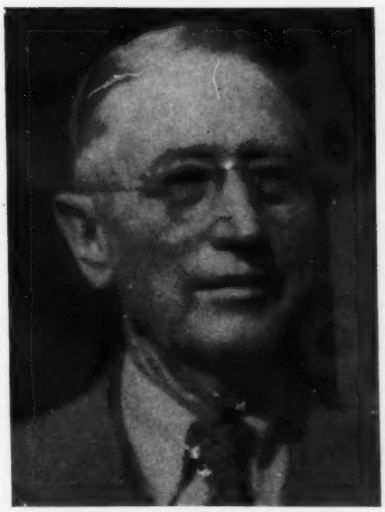
DR. GEORGE H. HAMPSHIRE

Dr. George H. Hampshire, Marlin, died February 26, 1960, in a Marlin hospital, following several weeks illness.

Born in St. Louis on January 30, 1878, Dr. Hampshire was a graduate of the Barnes Medical College, St. Louis. He completed his internship at the Los Angeles Hospital in Los Angeles. He was married in 1907 to Miss Lilian Garrett of Houston, who died October 7, 1959.

Dr. Hampshire had practiced medicine in Stranger, Kosse, Marlin, and Wichita Falls, returning in 1931 to Marlin. Following a postgraduate course in 1918 in New York, he had specialized in urology. He was on the staff of two clinics in Marlin, although at the time of his death he was serving with the Torbett Clinic.

A member of the American Medical Association, an honorary member of the Texas Medical Association, and a past president of the Falls County Medical Society, Dr.



DR. C. S. CARTER

DR. GEORGE H. HAMPSHIRE

Hampshire had belonged also to the Masket Shrine Temple at Wichita Falls and was a thirty-second degree Mason. He was a Methodist and a former Rotary Club member. For many years he had served as examining physician for the Lone Star Gas Company in Marlin.

Survivors include his daughter, Mrs. Louian C. Carter and two grandchildren, Port Arthur.

DR. C. B. YOUNG

Dr. Cuthbert B. Young, Tyler, died March 17, 1960, at his home following a short illness.

Dr. Young was born November 27, 1907, at Graham, Minn., and received his preliminary education in the Royalton, Minn., public schools. He was graduated from the University of Minnesota with a bachelor of science degree in 1931. His medical degree, which had been delayed by illness, was awarded to him in 1937 by the University of Minnesota Medical School. He interned at Minneapolis General Hospital, Minneapolis.

Before completing his M.D., he had served with the Federal Transient Division and he had served as camp

DR. C. B. YOUNG

surgeon at Lamont, Iowa, with the Civilian Conservation Corps.

He moved to Tyler in 1937, serving for 5 years as school physician. Opening his private practice in 1943, Dr. Young was staff physician at Mother Frances Hospital and Medical Center Hospital and he was consulting physician at East Texas Tuberculosis Hospital.

A member of the American Medical Association and the Texas Medical Association, Dr. Young served as president of the Smith County Medical Society in 1958.

He was a fellow of the American College of Chest Physicians, a member of the American Trudeau Society, an associate member of the American College of Allergists, a member of the board of directors of the Texas Tuberculosis Association, and a charter member of the Smith County Tuberculosis Association. He belonged to Phi Chi Medical fraternity. For several years he had served on the Tyler School Board. He had been a recipient of the distinguished service key award of the Junior Chamber of Commerce for his participation in the establishment of a tuberculosis clinic in Tyler.

A Methodist, Dr. Young belonged to the Masonic order, Scottish Rite and Shrine.

Survivors include his wife, Mrs. Vivian Young, Tyler; one son, John Young, Tyler; two daughters, Mrs. Patricia Cain, Dallas, and Mrs. Yvonne Hyde, Austin; his mother, Mrs. Anna Young, Park Ridge, Ill.; a brother, Homer Young of San Luis Obispo, Calif.; three sisters, Miss Olivia Young, Portland, Ore.; Mrs. Irene Aker, Foley, Minn.; and Mrs. Lucille Phinney, Park Ridge, Ill.; and two grandchildren, Polly Lou Cain and Randall Scott Hyde.

DR. F. A. BLOOM

Dr. Fred Akard Bloom, Houston, chief of orthopedic surgery at Jefferson Davis Hospital and clinical professor at Baylor University College of Medicine, died March 16, 1960.

Stricken while playing golf at River Oaks Country Club, Dr. Bloom died apparently of a heart attack.

Born October 26, 1902, in Weatherford, Dr. Bloom received his preliminary education there and was graduated in 1925 from the University of Texas, Austin. In 1931, he was awarded the medical degree from the University of Texas Medical Branch, Galveston. He had served as a staff member of the Southern Pacific General Hospital, San Francisco, was a resident in orthopedics at Children's Hospital, Los Angeles, and was a resident at the Ruptured and Crippled Hospital, New York. During World War II, Dr. Bloom served briefly as a naval physician.

Dr. Bloom was a partner at the Chelsea Orthopedic Clinic, Houston, in addition to his hospital and professorial duties. He was a member of the American Medical Association, the Texas Medical Association, and the Harris County Medical Society, and he belonged to the Methodist Church, the Rotary Club, the Doctor's Club, the River Oaks Country Club, and the Houston Orthopedic Society.

Survivors include his wife and a son, Dalton, both of Houston.

DR. F. A. BLOOM